Manulife

ATTENDING PHYSICIAN'S STATEMENT (DISABILITY CLAIM)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician/ Surgeon at Insured's expense.

1. PATIENT'S PARTICULARS

Name of Patient: _____ NRIC/Passport No: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Patient's Occupation: _____

2. CONSULTATION FOR PRESENT ILLNESS/ INJURY (IES)

(a) Date of first consultation with you: _____ / _____ / _____
dd mm yyyy

(b) Date of last consultation with you: _____ / _____ / _____
dd mm yyyy

(c) Date of first hospitalisation: From _____ / _____ / _____ to _____ / _____ / _____
dd mm yyyy dd mm yyyy

(d) Date of recent hospitalisation: From _____ / _____ / _____ to _____ / _____ / _____
dd mm yyyy dd mm yyyy

(e) If the consultation was for illness/injuries, please provide the following information:

(i) What symptoms did the patient complain of when he/ she first saw you for this condition?

_____

_____

_____

(ii) How long has he/ she been experiencing these symptoms?

_____

_____

(iii) In your medical opinion, how long do you think the patient has actually experienced these symptoms?

_____

_____

(iv) What was the diagnosis?

_____

_____

_____

(v) Date of diagnosis: _____ / _____ / _____
dd mm yyyy

(vi) Diagnosis was first made by (Name and Address of doctor): _____

_____

(vii) Date diagnosis was made known to the patient: _____ / _____ / _____
dd mm yyyy

(viii) Please describe the type of treatment provided, including any operations performed.

_____

_____

_____

(ix) Was the patient under the influence of alcohol? □ Yes □ No

If yes, what was the blood alcohol content? _____

(x) Was the Patient under the influence of any other drugs? □ Yes □ No

If yes, please provide name of drugs and results of any blood tests performed.

_____

(xi) Is the condition self-inflicted? □ Yes □ No

If yes, please provide details.

_____

(f) If the condition was a result of an accident, please provide the following information:

(i) Please provide information on how the accident happened.

_____

_____

_____

Date of Accident: _____ / _____ / _____
dd mm yyyy

(ii) Please describe the injuries suffered by the patient.

_____

_____

(iii) Was the patient under the influence of alcohol at the time of accident? □ Yes □ No

If yes, what was the blood alcohol content? _____

(iv) Was the patient under the influence of any other drugs? □ Yes □ No

If yes, please provide name of drugs and results of any blood tests performed.

_____

(v) Is the condition self-inflicted? □ Yes □ No

If yes, please provide details.

_____

_____

(vi) Please describe the type of treatment provided, including any operations performed.

_____

_____

3. PATIENT'S CONDITION

(a) Please describe fully the nature and severity of the patient's disability.

_____

_____

_____

_____

_____

(b) Is his/ her disability progressive, stationary or improving?

_____

(c) How is the patient's current condition?

_____

_____

_____

(d) Is full recovery expected? □ Yes □ No

If yes, please state approximate date: _____ / _____
mm yyyy

If no, please state the extent of recovery and approximate date.

_____

_____

(e) Has there been any improvement since you first saw the patient?

_____

_____

(f) Is the patient following recommended treatment program, if any?Please comment or describe nature of treatment.

_____

_____

(g) Please provide full details with respect to the patient's mental abilities and cognition.

_____

_____

_____

(h) Please indicate the past and present treatment, including medication for this condition?

_____

_____

_____

(i) What treatment is planned for the future?

_____

_____

_____

(j) Is there a history of this condition or any condition likely to have contributed to or be connected with the patient's present condition? □ Yes □ No

If yes, please provide details.

_____

_____

_____

(k) Please provide a full history of all consultations and treatments for the patient.

Date	Reasons for consultations including nature of symptoms and diagnosis and results of tests performed	Treatment Prescribed	Results

(l) Is there a family history of this condition? □ Yes □ No

If yes, please provide information such as relationship to insured, age first diagnosed, nature of condition and age at onset etc.

_____

_____

_____

_____

_____

_____

(m) Are you completing claim forms on behalf of the patient for any other insurance companies in relation to this condition? □ Yes □ No

If yes, please provide the name of the company (ies).

_____

_____

For Questions (n) to (r), please refer to the attached claim form for details of the patient's occupation.

(n) Is the patient able to perform all the normal duties of his/ her usual occupation? □ Yes □ No

If yes, when is he/ she expected to return to his/ her usual occupation? _____ / _____
mm yyyy

(o) If he/she is unable to return to his/ her usual occupation, is he/she able to engage in any other occupation?

□ Yes □ No

If YES, please provide us the following details.

(i) What types of occupation can he/ she engage in?

_____

_____

(ii) When is he/ she expected to engage in these occupations? _____ / _____
mm yyyy

If NO, to what extent does the disability prevent the patient from performing all the normal duties of his /her occupation, i.e. _____?

(p) Date the patient was obliged to cease work? _____ / _____ / _____
dd mm yyyy

(q) In your opinion, is the disability " total and permanent and such that there is neither then nor at any time thereafter any work, occupation or profession that the person concerned can ever sufficiently do or follow to earn to obtain any wages, compensation or profit"? □ Yes □ No

If yes, when did such commence? _____ / _____ / _____
dd mm yyyy

(r) Please provide full details of the patient's capabilities and limitations in relation to his/ her occupation.

(i) Capabilities (what the patient can do)

_____

_____

_____

_____

(ii) Limitations (what the patient cannot do)

_____

_____

_____

_____

4. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

(i) Name and Address of referral doctor: _____

_____

(ii) Name and Address of clinic/ hospital: _____

_____

(iii) Date referred: _____ / _____ / _____
dd mm yyyy

(b) Did the patient consult other doctors for this illness or its symptoms before he/ she consulted you?

□ Yes □ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom he/ she consulted.

Name of Doctor	Name and Address of Clinic/ Hospital	Dates of Consultation

(c) Has the patient been admitted to hospital before for the same illness or injury? □ Yes □ No

If yes, please provide the following details.

Date of Admission	Date of Discharge	Name of Hospital

(d) Is the patient suffering or has suffered from any other significant illnesses? □ Yes □ No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

(e) Are you the patient's regular doctor? □ Yes □ No

If yes, since when? _____ / _____ / _____
dd mm yyyy

If no, please provide the name and address of the patient's regular doctor.

_____

_____

_____

(f) Please give any other information which you feel would be helpful in assessment of the patient's claim.

_____

_____

_____

_____

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)