

## ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS BLINDNESS

Pat	ient's Name					
Attending Physician's Name		Address				
Thi	s section must be completed by a qualified and regi	stered physician at the expense of the claimant.				
bee		of certain contingent events associated with his/her health. A claim has ole us to assess the claim, we would be grateful for your cooperation in				
A.	GENERAL INFORMATION					
1.	Are you the patient's usual medical doctor?	Yes No				
	If yes, over what period do your records extend to?					
	Start date////	End date////////				
2.	When did the patient first consult you for this condition					
3.	Please state symptoms presented and date symptoms first appeared.					
	Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)				
4.	In your opinion what were the likely durations of the pa	ıtient's symptoms? Please provide reasons.				
5.	Did the patient consult any other doctors for these symptoms before he/she consulted you? Yes No If yes, please provide details below.					
	Name of Doctor	Name of Clinic/ Hospital and Address				
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	What is the diagnosis? Please provide full	details of the diagnosis	S		
(b)	Date of onsetdd	/	/		
(c)	Date of diagnosis dd	/	/		
(d)	Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.				
	Name of Doctor	Na	me of Clinic/ Ho	ospital and Addres	SS
d)	Date when patient was first made aware of the diagnosis?  / / / / yyyy				
(e)	Was the patient admitted in the hospital?  Yes  No				
	If yes, please provide the following details.  Name / Address of Hospital				
	Date of Admission	Date Discharged _		No. of	Days
(a)	Please describe the extent of Blindness.				
(b)	Do you consider the Blindness as total and irreversible loss of all sight of both eyes? Yes No				
	If yes, please provide basis for details.				
	ase provide details of current treatment provided.				

9.	Manulife  What is the prognosis?			
10. Please provide full details of tests and results which have been performed to establish the diagnosis of Blindness copies of all relevant hospital reports, laboratory and test results, including neurological reports, CT scans, MF imaging studies and surgical reports.				
11.	Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of doctors consulted.			
	Name of Doctor	Name of Clini	c/ Hospital and Address	
C.	MEDICAL HISTORY			
12.	Has the patient previously suffered from	om the condition specified above or any rela	ted illnesses? Yes No	
	If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending. Please state source of information.			
	Date of Consultation	Name of Doctor / Address	Diagnosis	

Date of Consultation	Name of Doctor / Address	Diagnosis

If yes, please provide details including the date of consultations, their resulting diagnosis, name and address of attending doctor. Please state source of information.

13. Is there anything in the patient's medical history which would have increased the risk of Blindness?

☐ No

Yes

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	PRC Number / PTR Number	Telephone Number (s)
	Signature	Date Signed
	Name of Attending Physician (Please print)	Degree/Specialty
I he	reby certify that the above statements are true and complete	to the best of my knowledge and belief.
18.	Please provide us with any other additional information that will enable	the Company to assess this claim.
D.	ADDITIONAL INFORMATION	
	If yes, please provide details of the condition, including diagnosis, dareceived.	ate of diagnosis, duration of condition(s) and treatment
17.	Does the patient have or ever had any other significant health condition	n(s)?
	day. Please state source of information.	
16.	Please give details of the patient's habits in relation to alcohol consumday. Please state source of information	nption, including the amount of alcohol consumption per
	number of cigarettes smoked per day. Please state source of information	on.
15.	Please give details of the patient's habits in relation to past and pres	ent smoking, including the duration of smoking habits,
14.	Please give details of the patient's family history which would have incr nature of illness, date of diagnosis) Please state source of information	

To the Attending Physician: You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.