Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: 1 800 1 888 6268
Website: www.manulife.com.ph
Email:phcustomercare@manulife.com

Attending Physician's Statement
(Total and Permanent Disability Claim)

Policy Number	Claimant's Name (Last, First, MI)

Physician's Information

Name of Physician (Last, First, MI)

Hospital Address (Number, Street, Bldg, Barangay, Town/City, State, Country, ZIP Code)

Email Address	Mobile Number

Declaration and Details of Claim

How long have you known the insured? _____ What's the occupation of the insured? _____

Date of ÿrst consultation (mm/dd/yyyy) _____ Date of last consultation (mm/dd/yyyy) _____

Symptoms presented at first consultation	Date symptoms first started (mm/dd/yyyy)

Other physician/s to your knowledge who attended to the claimant:

Physician/s Name	Address	Date (mm/dd/yyyy)	Diagnosis/Treatment

Consultation Details:

Date/s (mm/dd/yyyy)	Complaints & Physical examination findings	Duration of Illness	Diagnosis	Describe treatment/procedure

What is the diagnosis? Describe the full and exact diagnosis of the condition causing the total and permanent disability.

Date of Diagnosis (mm/dd/yyyy) _____

Provide details where the diagnosis was first made:

Name of Doctor	Hospital/Clinic and Address	Date of First Consultation (mm/dd/yyyy)	Telephone Number

Date when patient was first made aware of the diagnosis (mm/dd/yyyy) _____

Is the disability due to an accident? ☐ Yes ☐ No

If yes, provide date and time of the accident (mm/dd/yyyy) _____ Time _____

Details of accident and injuries of the insured:

Patient's Condition

Describe the nature and severity of the patient's current disability _____

Is the patient confined to a home, hospital or similar institution that provides constant care and medical attention? ☐ Yes ☐ No

What's the current patient's range/capacity of movement? _____

Does the patient have full control of all limbs? ☐ Yes ☐ No

If no, which limb/s does not have full control and the corresponding muscle power? _____

What is the likelihood of improvement in motor function over time? Very likely Likely Not likely

Provide details with respect to the patient's mental abilities and cognition:

Describe the past and current treatment provided, including any operations performed and whether it is likely to improve the patient's condition.

Is the patient compliant with the recommended treatment program? ☐ Yes ☐ No If no, provide details:

What other treatment/s are planned for the future? _____ How often is the patient's check-up for this condition? _____

List all patient's pre-disability major duties relative to his/her occupation:

Duties	Percentage of time spent per day (%)

List all duties that the patient is unable to do due to the disability relative to his/her occupation:

Duties	Percentage of time spent per day (%)

Is the patient able to perform all the normal duties of his/her current condition? ☐ Yes ☐ No

If yes, when will the patient be able to return to work? (mm/dd/yyyy) _____

If no, when did he/she cease all work? (mm/dd/yyyy) _____

Can the patient still seek other employment or occupation including voluntary employment? ☐ Yes ☐ No

If yes, what type of work/occupation can the patient engage in? _____

When can he/she engage in these occupations? (mm/dd/yyyy) _____

In your opinion, is the patient totally and permanently disabled as a result of an injury or disease and is unable to engage in any occupation or perform any work for income or profit currently or anytime thereafter? ☐ Yes ☐ No

If yes, when did it commence? (mm/dd/yyyy) _____

Is the disability due to total and irrecoverable loss of sight on both eyes? ☐ Yes ☐ No

Is the disability due to loss by severance of two limbs at or above the wrist or ankle? ☐ Yes ☐ No

Is the disability due to total and irrecoverable loss of sight on one eye and loss by severance of the limb at or above the wrist or ankle? ☐ Yes ☐ No

Provide details:

Is the disability due to any self-inflicted act or attempt to suicide? ☐ Yes ☐ No
If yes, provide details:

Is the disability due to patient under the influence of alcohol or any drug? ☐ Yes ☐ No
If yes, provide details:

Is the disability due to any mental and nervous disorder? ☐ Yes ☐ No
If yes, provide details:

Is full recovery expected? ☐ Yes ☐ No
If yes, provide the expected date of recovery (mm/dd/yyyy) _____
If no, provide prognosis of the patient's condition:

Medical History

Did the patient previously suffer from any related illness/es that caused the present condition? ☐ Yes ☐ No
If yes, provide details:

Is there a family history of this condition? ☐ Yes ☐ No
If yes, provide details (including the relationship to insured, nature of illness, date of diagnosis and sources of the information):

Provide details of the patient's family history, which would increase the risk of the condition resulting in resulting in Terminal Illness (including the relationship, nature of illness and date of diagnosis):

Does the patient have or ever had any other significant health conditions? ☐ Yes ☐ No
If yes, provide details:

Other physicians to your knowledge who attended to the patient in relation to the Medical History:

Name	Address	Date (mm/dd/yyyy)	Diagnosis/Treatment

Provide any other additional information including specialist or hospital records, test results and reports that will enable the company to asses this claim: (use additional sheets of paper if more space is needed for the information)

Declaration and Certification

I hereby certify that the above statements are true and complete to the best of my knowledge and based from available records

I authorize Manulife's Medical Doctor or any of his authorized representative/s or other person/s in Manulife's employ or under contract with Manulife to request and/or secure from me or any medical practitioner/facility/hospital/clinic or any entity, the medical records of the insured (above named patient). I agree that a photographic copy of this authorization shall be valid as the original.

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

_____	_____	_____	_____
Physician's Signature over Printed Name	PRC Number	Date (mm/dd/yyyy)	Place Signed
_____	_____	_____	_____
Financial Adviser/Witness Signature over Printed Name	FA Code	Date (mm/dd/yyyy)	Place Signed