Manulife

CRITICAL ILLNESS CLAIM - ATTENDING PHYSICIAN'S STATEMENT BRAIN, NERVE, BONE, JOINT, MUSCLE, TISSUE RELATED ILLNESS

(This form to be completed by patient's attending doctor/specialist at patient own expense)

Claim was filed for following illness: (Please tick [✔] for appropriate box)

☐ Stroke	☐ Coma	☐ Encephalitis	☐ Paralysis of Limb
☐ Multiple Sclerosis	☐ Major Head Trauma	☐ Benign Brain Tumour	☐ Major Burns
☐ Alzheimer's Disease	☐ Apallic Syndrome	☐ Brain Surgery	☐ Muscular Dystrophy
☐ Parkinson's Disease	☐ Bacterial Meningitis	☐ Motor Neuron Disease	☐ Poliomyelitis

Patient's Personal Details

Policy No.	1)
	2)
	3)
	4)
Name of Patient	
New IC/Old IC/Passport No/Birth Cert	
Date of Birth	

A PATIENT'S MEDICAL RECORD (THIS SECTION IS COMPULSORY TO FILL UP FOR ALL CRITICAL ILLNESSESS)

1. Are you the patient's regular/family doctor? If yes, when did the records extend?	☐ Yes ☐ No Date: .... /............... /.................. (DD) (MM) (YYYY)
2. Date when patient first consulted you for the illness.	Date: .... /............... /.................. (DD) (MM) (YYYY)

3. The presenting symptoms during first consultation with you and how long did the symptoms lasting.

Sign & Symptoms	Duration

Where is the source of this information?

☐ Patient

☐ Referring Doctor (Name of doctor and hospital/clinic) ....

☐ Others, please specify: ....

4. Please describe the full and exact diagnosis with investigation/test taken and treatment given.

Date (dd/mm/yyyy)	Diagnosis	Type of investigation/test	Treatment

5. Date when the patient was informed of the diagnosis.	Date: .... /............... /.................. (DD) (MM) (YYYY)

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Manulife Insurance Berhad Registration No. 200801013654 (814942-M)
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6. **Has the patient ever suffered from or diagnosed to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischemic attack, neurological disorder, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?**

☐ Yes ☐ No

If "Yes", please provide following details:

Date of diagnosis	Illnesses	Medication/Treatment	Name of Doctor	Name and address of clinic/hospital

7. **Please provide us with other information that enable the Company to assess this claim.**

....

....

B (This section is only applicable for SPECIFIC CRITICAL ILLNESSESS only)

I. **Applicable for**
- Brain - Stroke (to be complete by Neurologist), or
- Multiple Sclerosis (to be complete by Neurologist), or
- Alzheimer's Disease, or
- Parkinson's Disease, or
- Coma (to be complete by Neurologist), or
- Major Head Trauma (to be complete by Neurologist), or
- Apallic Syndrome (to be complete by Neurologist), or
- Bacterial Meningitis (to be complete by Neurologist), or
- Encephalitis (to be complete by Neurologist), or
- Benign Brain Tumour, or
- Brain Surgery

1. (a) For **Stroke,** please confirm what is the underlying cause of illness? Please tick the relevant.

and provide date of onset. Date: .... /................ /..................
(DD) (MM) (YYYY)

☐ Infarction ☐ Embolisation ☐ Arterio-venous malformation

☐ Hemorrhage ☐ Head Injury ☐ Others, please specify: ....

(b) Did patient sufferred from any neurological deficit? ☐ Yes ☐ No

If Yes, please state the duration of deficits. .... /..................
(Years) (Months)

(c) Are the neurological deficit permanent with persistent clinical symptoms/sign in the rest of lifetime of patient?

☐ Yes ☐ No

If Yes, please state the persistent symptoms/sign.

....

(d) Is the patient still on continuous follow-up/treatment? ☐ Yes ☐ No

Please state the LAST follow-up date Date: .... /................ /..................
(DD) (MM) (YYYY)

(e) Is the diagnosis fall under any of the following condition?

☐ Transient Ischemic Attack ☐ Cerebral symptom due to migraine

☐ Any reversible ischemic neurological deficit ☐ Cerebral injury due to trauma or hypoxia

☐ Vertebrobasilar ischemia ☐ Vascular disease affecting eye or optic nerve or vestibular function

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(f) Physical and Neurological Assessment:-

Date of latest/current assessment: **Date:** .... /............... /..................
(DD) (MM) (YYYY)

i. Vision (Visual Acuity)

	Left	Right
Normal		
Impaired		
Scores based on metric activity		

ii. Hearing (based on audiometry results)

	Left	Right
Normal		
Impaired		
Scores based on speech reception threshold		

iii. Speech function

☐ Clear and understandable ☐ Slurred ☐ Unable to speak

iv. Cognitive function

☐ Normal ☐ Poor comprehension ☐ Difficult with logic and reasoning ☐ Memory loss

v. General examination:

- Any abnormal movements or gaits? Please specify: ....
- Any muscle wasting? Please specify: ....
- Any other significant findings? Please specify: ....

vi. Examination of muscle power and range of movement of limbs with maximum grade of 5 being the highest.

Upper Limbs	Muscle Power		Range of Movement	
	Left	Right	Left	Right
Shoulder				
Elbow				
Wrist				
Grip				
Lower Limbs				
Hip				
Knee				
Ankle				

vii. Activities of Daily Living Assessment:

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

(h) What is the prognosis of the neurological impairments?

☐ Recovered ☐ Stable and improving ☐ No change, likely to be permanent

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan of brain, blood and laboratory test, neurological assessment, surgery report)

2. (a) For **Multiple Sclerosis,** please select the appropriate condition.

☐ Central Nervous System ☐ Peripheral Nervous System

(b) Any impairment on co-ordination and motor sensory function? ☐ Yes ☐ No

If Yes, please state the symptoms and its duration.

....

(c) Please state the extent of neurological deficits and its duration in details. .... /..................
(Years) (Months)

....

....

(d) Any history of multiple exacerbations and remissions? ☐ Yes ☐ No

If Yes, please indicate number of each with dates. ....

(e) Any evidence of multiplicity or discrete lesion on imaging studies? If Yes, please provide copies of reports.

☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan of brain, blood and laboratory test, neurological assessment, surgery report)

3. (a) For **Alzheimer's Disease,** please state the underlying cause of dementia.

☐ Alzheimer's Disease
☐ Drug related organic disorder
☐ Vascular Dementia
☐ Alcohol related organic disorder
☐ Neurosis or psychiatric illess
☐ Others, please specify: ....

(b) Please confirm the stage of Alzheimer's Disease:

☐ Stage 1: Normal outward behaviour
☐ Stage 2: Very mild changes
☐ Stage 3: Mild decline
☐ Stage 4: Moderate decline
☐ Stage 5: Moderately severe decline
☐ Stage 6: Severe decline
☐ Stage 7: Very severe decline

(c) Any significant reduction in mental and social functioning?

i. Deterioration or loss of intellectual capacity ☐ Yes ☐ No

ii. Abnormal behaviour ☐ Yes ☐ No

(d) Please state the scores of Mini Mental State Examination (MMSE) or any equivalent test done.

....

(e) Whether the patient required any continuous supervision? ☐ Yes ☐ No

If Yes, please specify ....

(f) Was the disease permanent and irreversible? ☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, neurological assessment, MMSE and all supporting clinical questionnaires, cerebral angiogram)

4. (a) For **Parkinson's Disease,** please state the underlying cause of illness.

☐ Idiopathic ☐ Drug-induced ☐ Toxin ☐ Autoimmune

(b) Any permanent clinical impairment of motor function associated with:-

i. Tremor ☐ Yes ☐ No

ii. Rigidity movement ☐ Yes ☐ No

iii. Postural instability ☐ Yes ☐ No

(c) Was the condition well controlled under medication? ☐ Yes ☐ No

If yes, please provide details: ....

(d) Any signs of progressive impairment? ☐ Yes ☐ No

If Yes, please provide details: ....

(e) Activities of Daily Living Assessment: Date: .... /................ /..................
(DD) (MM) (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, neurological assessment, cerebral angiogram)

5. (a) For **Coma,** please state onset date & its duration (continuously) for unconsciousness with no reaction/response to external stimuli/internal needs.

Date: .... /................ /.................. ....
(DD) (MM) (YYYY) (Hours)

(b) Was patient put on any life support system? ☐ Yes ☐ No

If Yes, please state the duration. ....
(Hours) (Days)

(c) Please state the score of Glasgow Coma Scale (GCS) or any equivalent test done.

....

(d) Any neurological deficits lasting more than 30 days after patient regain consciousness? ☐ Yes ☐ No

If Yes, please specify in details:..

(e) Was the condition resulting from any of the followings?

i. Alcohol ☐ Yes ☐ No

ii. Drug abuse/ misuse ☐ Yes ☐ No

iii. Self-inflicted injury ☐ Yes ☐ No

iv. Medically induced ☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, Glasgow Coma Scale Report, evidence of usage of Life Support System)

6. (a) For **Major Head Trauma,** please stated the exact date of injury. Date: .... /................ /..................
(DD) (MM) (YYYY)

(b) Please give details of the circumstance leading to the injury?

....

(c) Please provide exact location and extent of head injury.

....

(d) Was any surgery performed on the head injury? ☐ Yes ☐ No

If Yes, please specify: ....

(e) Was any functional impairment resulting from head injury? ☐ Yes ☐ No

If Yes, please specify in details and its lasting duration:

....

(f) Was the impairment expected to be permanent and beyonce any hope of recovery based on current medical knowledge and technology?

☐ Yes ☐ No

(g) Activities of Daily Living Assessment: Date: .... /................ /..................
(DD) (MM) (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, neurological assessment, biopsy, surgery report, police report)

7. (a) For **Apallic Syndrome,** is there presence of universal necrosis of the brain cortex with the brainstem remaining intact?

☐ Yes ☐ No

If Yes, please specify in details including its neurological deficits.

....

(b) Has the condition been medically documents and persisted for at least one month since onset?

☐ Yes ☐ No

If Yes, please specify in details and its duration with supporting medical reports (etc: EEG).

....

(c) Please stated the medical treatment/surgery given or any treatment planned in future.

....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, EEG report)

8. (a) For **Bacterial Meningitis** or **Encephalitis,** please state the causative agent of infection/inflammation.

☐ Bacterial ☐ Virus ☐ Fungus ☐ Others, please specify: ....

(b) Any lumbar puncture performed? ☐ Yes ☐ No

If yes, please provide cerebrospinal fluid (CSF) test result.

(c) Any neurological deficit resulting from the illness? ☐ Yes ☐ No

If Yes, please specify in details with duration: Date: .... /................ /..................
(DD) (MM) (YYYY)

....

(d) Was the neurological impairment expected to be permanent and beyonce any hope of recovery based on current medical knowledge and technology?

☐ Yes ☐ No

(e) Was the illness resulting from HIV infection? ☐ Yes ☐ No

(f) Activities of Daily Living Assessment: Date: .... /................ /..................
(DD) (MM) (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, neurological assessment)

9. (a) For **Brain Tumour,** please state nature of illness.

☐ Benign ☐ Malignant

(b) Please state the extent of tumour lesion and its staging.

....

(c) Was the tumour cause damage to brain? ☐ Yes ☐ No

(d) Was the tumour life-threatening in nature? ☐ Yes ☐ No

If Yes, please specify: ....

(e) Was the tumour giving rise to any characteristic sign of intra-cranial pressure? ☐ Yes ☐ No

If Yes, please state the relevant as below:

☐ Papilloedema ☐ Sensory Impairment

☐ Mental Symptoms ☐ Others, please specify: ....

☐ Seizures

(f) Was there any permanent neurological deficit with persisted clinical symptoms? ☐ Yes ☐ No

If Yes, please specify: ....

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(g) Has the tumour been surgically removed either partially or totally? ☐ Yes ☐ No

If Yes, please state the date of surgery and its approach:

....

(h) Was the illness fall under any of following condition?

i. Cyst ☐ Yes ☐ No

ii. Granulomas ☐ Yes ☐ No

iii. Malformations in or of the arteries or veins of the brain ☐ Yes ☐ No

iv. Haematomas ☐ Yes ☐ No

v. Tumors in the pituitary gland, or spine ☐ Yes ☐ No

vi. Tumors of the acoustic nerve ☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, biopsy)

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10. (a) For **Brain Surgery,** was the surgery performed under general anesthesia and involved opening of skull?
☐ Yes ☐ No

If Yes, please state the exact date of operation. Date: .... /............... /.................
(DD) (MM) (YYYY)

(b) What is the circumstance leading to the surgery?
☐ Illness ☐ Accident

(c) Please stated the approach of surgical/procedure that performed.

i. Craniotomy ☐ Yes ☐ No

ii. Burr hole procedures ☐ Yes ☐ No

iii. Transphenoidal procedures ☐ Yes ☐ No

iv. Endoscopic assisted procedures ☐ Yes ☐ No

v. Others minimally invasive procedures ☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, biopsy)

II. Applicable for Nerve - Motor Neuron Disease (to be complete by Neurologist)

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1. (a) For Motor Neuron Disease, please indicated characteristic of the illness.
☐ degenerative of corticospinal tract ☐ degenerative of bulbar efferent neurons
☐ degenerative of anterior horn cells ☐ Others, please specify: ....

(b) Please stated the types of motor neuron disease.
☐ Spinal Muscular Atrophy ☐ Primary Lateral Sclerosis
☐ Progressive Bulbar Palsy ☐ Others, please specify: ....
☐ Amytrophic Lateral Sclerosis

(c) Was there any permanent neurological deficit with persisted clinical symptoms (etc: sensory, motor, autonomic)?
☐ Yes ☐ No

If Yes, please specify: ....

(d) Please stated the medical treatment/surgery given or any treatment planned in future.

....

(e) Any signs of progressive impairment? ☐ Yes ☐ No

If Yes, please provide details: ....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, biopsy, electromyography, nerve conduction studies, CSF studies)

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III. Applicable for - Bone, Joint, Muscle, Tissue - Paralysis of Limb
- Major Burns
- Muscular Dystrophy (to be complete by Neurologist)
- Poliomyelitis (to be complete by Neurologist)

1. (a) For **Paralysis of Limb,** please state the underlying cause of condition.

☐ Illness ☐ Accident

(b) If caused by Illness, please specify in details.

....

If caused by Accident, please provide accident details (date, time, how accident happened)

....

(c) Was the loss of use of function involve at least 2 or more limbs? ☐ Yes ☐ No

Please specify in details: ....

(d) Please state the condition of illness and its duration involved. Date: .... /................ /..................
(DD) (MM) (YYYY)

☐ Complete & Permanent ☐ Partial & Temporary

(e) Examination of muscle power and range of movement of limbs with maximum grade of 5 being the highest.

Date: .... /................ /..................
(DD) (MM) (YYYY)

Upper Limbs	**Muscle Power**		**Range of Movement**	
	Left	Right	Left	Right
Shoulder				
Elbow				
Wrist				
Grip				
Lower Limbs				
Hip				
Knee				
Ankle				

(f) Activities of Daily Living Assessment: Date: .... /................ /..................
(DD) (MM) (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, neurological assessment)

2. (a) For **Major Burn,** please provide details of incident/accident (date, time, how was it happened)

....

(b) Was the burn due to self-inflicted? ☐ Yes ☐ No

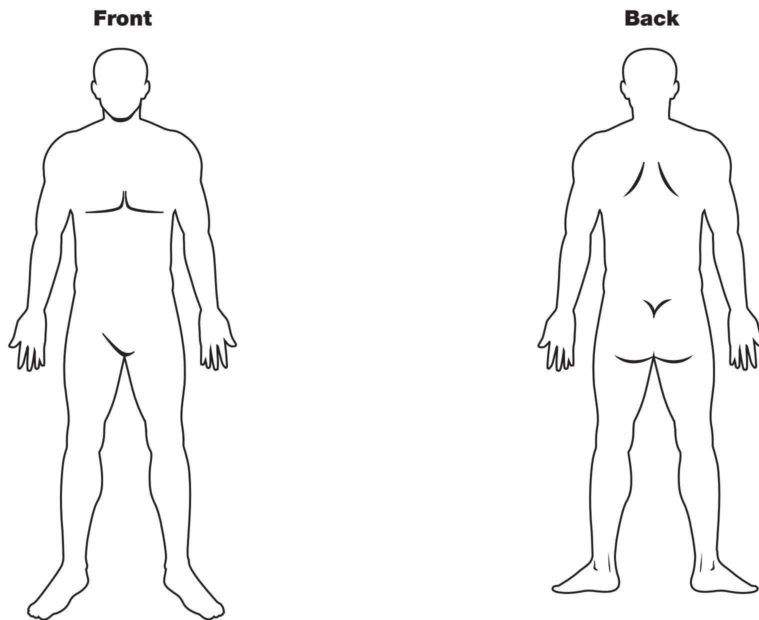
(c) Please state the extent of burn in terms of depth and size (percentage of affected body surface area by "The Rule of 9" of Lund & Browder Body Surface Chart.

Depth of Burn	Affected body surface area and its percentage
First Degree	
Second Degree	
Third Degreee	
Fourth Degree	

(d) Any skin grafting done or in scheduled? ☐ Yes ☐ No

If Yes, please indicate date of surgery. Date: .... /................ /...................
(DD) (MM) (YYYY)

(e) Please indicate the burnt areas on the Total Body Surface Area Burns Assessment Figure. (Please provide copy of the report for its supporting). Kindly highlight all the burnt areas and specify the areas with Third Degree Burns



Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, Lund & Browder Body Surface Chart Radiological, police report)

3. (a) For **Muscular Dystrophy,** please stated the type of illness.

☐ Duchenne's
☐ Facioscapulohumeral
☐ Myotonic
☐ Congenital
☐ Others, please specify: ....

(b) Are the neurological deficits likely to be permanent and beyonce any hope of recovery?

☐ Yes ☐ No

If Yes, please specify in details: ....

(c) Was any clinical presentation including ABSENCE of sensory disturbance, normal cerebro-spinal fluid or mild tendon reflex reduction?

☐ Yes ☐ No

If Yes, please specify in details: ....

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(d) Was there wasting or weakness of muscles? (Please state the power of affected muscles with scoe 1 being the lowest & 5 being the highest)

Date	Affected muscles & muscle power

(e) Activities of Daily Living Assessment: Date: .... /................ /..................
(DD) (MM) (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

(f) Any investigation tests done to confirm the diagnosis? Please provide copy of the report for its supporting.

☐ Electromyogram ☐ Muscle Biopsy ☐ Others, please specify: ....

(g) Was there any familiy history of similar or related illness? ☐ Yes ☐ No

If Yes, please sttae the relationship, nature of illness & date of first diagnosed.

....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, neurological assessment, biopsy, electromyogram)

4. (a) For **Poliomyelitis,** was Paralysis involved due to the illness? ☐ Yes ☐ No

If Yes, please specify the extent of Paralysis and its muscle power.

....

(b) Was there any evidence of impaired motor function or respiratory weakness? ☐ Yes ☐ No

If Yes, please specify: ....

(c) What is the underlying cause of Paralysis?

☐ Polio Virus ☐ Congenital
☐ Guillain-Barre Syndrome ☐ Others, please specify: ....
☐ Injury

(d) Please stated the medical treatment/surgery given or any treatment planned in future.

....

(e) Was there any factor in patient's habits, family history or personal medical history increase risk of Poliomyelitis?

☐ Yes ☐ No

If Yes, please specify: ....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report)

C ATTENDING DOCTOR'S DECLARATION

I, the undersigned, certify that I have examined the above Life Assured and that I have answered the above questions are true and to the best of my knowledge and belief.

Signature of the Attending Doctor

Name & practice stamp

Name of the Attending Doctor : ....

Official Stamp of the Attending Doctor : ....

Professional Qualification : ....

Name & Address of Hospital/Clinic :

....

....

Contact No. : ....

Date: .... /................ /..................
(DD) (MM) (YYYY)

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