Manulife

CRITICAL ILLNESS CLAIM - ATTENDING PHYSICIAN'S STATEMENT OTHER ILLNESSES

(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)

- ☐ Blindness
- ☐ Deafness
- ☐ Loss of Speech
- ☐ Loss of Independent Existence
- ☐ Terminal Illness
- ☐ HIV Infection due to Blood Transfusion
- ☐ Occupationally Acquired HIV Infection
- ☐ Full Blown Aids
- ☐ Major Organ/Bone Marrow Transplant
- ☐ Chronic Aplastic Anaemia

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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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.

.....

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

I. Applicable for - Blindness (to be complete by Opthalmologist), or
- Deafness, or
- Loss of Speech, or
- Loss of Independent Existence, or
- Terminal Illness

1. (a) For Blindness, please state the underlying cause of illness? Please tick the relevant.

☐ Corneal Scarring ☐ Others, please specify: .....

☐ Optic Nerve Atrophy

(b) What is the visual acuity of noth eyes during last consultation (measured by Snellen Eye Chart or any equivalent test)

☐ Yes ☐ No

Date of consultation	Visual Acuity	Visual Field
	Left Eye (Uncorrected):	Left Eye (Uncorrected):
	Right Eye (Uncorrrected):	Right Eye (Uncorrrected):
	Left Eye (Corrected):	Left Eye (Corrected):
	Right Eye (Corrrected):	Right Eye (Corrrected):

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

.....

(d) Was the loss of sight permanent and irreversible?

i. Left Eye ☐ Yes ☐ No

ii. Right Eye ☐ Yes ☐ No

(e) Was any surgical intervention or treatment based on current medical technology and knowledge that could reinstate vision of eye(s)?

☐ Yes ☐ No

Please Yes, please specify: .....

(f) Was there any factor in patient's habits, family history, occupational hazards or personal medical history increase risk of Blindness?

☐ Yes ☐ No

Please Yes, please specify: .....

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

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

.....

(h) Please provide the prognosis of illness.

.....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, audiometry, sound threshold test, blood and laboratory test)

3. (a) For **Loss of Speech,** please state the underlying cause of diagnosis?

☐ Illness ☐ Accident

Please specify in details .....

(b) Was the inability of speak related to illness or injury to vocal cord? ☐ Yes ☐ No

If Yes, please specify .....

(c) Please confirm the loss of speech condition and its duration

i. Total ☐ Yes ☐ No Date: ..... /..... /.....
(DD) (MM) (YYYY)

ii. Permanent ☐ Yes ☐ No Date: ..... /..... /.....
(DD) (MM) (YYYY)

iii. Irrecoverable ☐ Yes ☐ No Date: ..... /..... /.....
(DD) (MM) (YYYY)

iv. Psychiatric related ☐ Yes ☐ No Date: ..... /..... /.....
(DD) (MM) (YYYY)

(d) Was any surgical intervention, or treatment based on current medical technology and knowledge that could reinstate the speaking ability?

☐ Yes ☐ No

If Yes, please specify .....

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

☐ Yes ☐ No

If Yes, please specify .....

(f) Was there any familiy history of similar or related illness?

☐ Yes ☐ No

If Yes, please specify .....

(g) Please provide the prognosis of illness.

.....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, medical evidence to confirm illness or injury to vocal cord, blood and laboratory test)

4. (a) For **Loss of Independent Existence,** please state the underlying of the condition.

☐ Illness ☐ Accident

Please specify in details .....

(b) Please decribe the latest physical or mental impairment based on consultation date.

Date	Physical or Mental Impairment

(c) Please provide details of completed, current or planned treatment for the illness.

.....

(d) Was there any completed or planned surgery for the illness? ☐ Yes ☐ No

If Yes, please specify with date and details of surgery performed.

.....

(e) Was patient bedridden? ☐ Yes ☐ No

If Yes, please state its duration. Date: ..... /..... /.....
(DD) (MM) (YYYY)

(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			

(g) Please state the duration of inability. Date: ..... /..... /.....
(DD) (MM) (YYYY)

(h) Was any surgical intervention, or treatment based on current medical knowledge and technology that could reinstate the inability?

☐ Yes ☐ No

If Yes, please specify .....

(i) Was the inability permanent and beyonce any hope of recovery? ☐ Yes ☐ No

(j) What is the prognosis of the illness?

☐ Retrogressed ☐ Improving ☐ Static ☐ Recovered

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, neurological assessment, blood and laboratory test)

5. (a) For **Terminal Illness,** please provide symptoms, date of consultation, diagnosis.

Date (dd/mm/yyyy)	Symptoms	Date of consultation	Diagnosis

(b) Was the condition incurable and beyonce any hope of recovery? ☐ Yes ☐ No

(c) Was the condition reached terminal stage based on your opinion? ☐ Yes ☐ No

(d) What is the estimated life expectancy based on your opinion with justification.

.....

(e) What is the current treatment given to patient and its effectiveness.

.....

(f) Was active therapy been ceased or rejected in favour of palliative care? ☐ Yes ☐ No

If Yes, please specify .....

(g) Was patient ever been tested positive for HIV or AIDS; or awaiting for the test results? ☐ Yes ☐ No

If Yes, please specify .....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, blood and laboratory test)

II. Applicable for - HIV Infection due to Blood Transfusion, or
- Occupationally Acquired HIV Infection, or
- Full Blown Aids

1. (a) Please stated how did the patient contract to HIV infection.

i. Intravenous drug use ☐ Yes ☐ No

ii. Sexual activity ☐ Yes ☐ No

If Yes, please indicate patient is homosexual, multiple sexual partner, sexual worker or spouse with HIV infection

.....

iii. Blood transfusion ☐ Yes ☐ No

iv. Maternal-fetal transmissiom ☐ Yes ☐ No

v. Occupational exposure ☐ Yes ☐ No

If Yes for Occupational exposure, please stated below in details:

Actual Occupation	
Place of Work	
Details of the incident	
Details of post-exposure management	

vi. Haemophilia ☐ Yes ☐ No

vii. Others, please specify .....

(b) How did the patient become aware of the HIV positive status?

☐ Incidental findings ☐ Symptomatic. Please specify in details with onset date .....

(c) Was any HIV antibody/Western Blot/CD4 cell count test done before the incident? ☐ Yes ☐ No

If Yes, please attached a copy of the said report.

(d) Was any HIV antibody/Western Blot/CD4 cell count test done after the incident? ☐ Yes ☐ No

If Yes, please attached a copy of the said report.

(e) If the HIV infection contracted through blood transfusion, please state date and reason for blood transfusion.

.....

(f) Was the blood transfusion medically necessary or given part of the treatment? ☐ Yes ☐ No

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

(g) Was the blood transfusion received in Malaysia ot Singapore? ☐ Yes ☐ No

(h) Was the source of HIV infection (through blood transfusion or occupational acquired) established from the hospital/clinic?

☐ Yes ☐ No

If Yes, please stated the name and address of the Hospital/Clinic.

.....

(i) Was the instituition able to trace the origin of the HIV tainted blood? ☐ Yes ☐ No

If Yes, please specify .....

(j) Any statement from Statutory Health Authority confirming the infection was acquired through blood transfusion or occupational injury incident?

☐ Yes ☐ No

If Yes, please provide a copy as proof of incident.

(k) For occupatinally acquired HIV infection, please confirmed whether patient is a medical staff that registered under Ministry of Health of Malaysia.

☐ Yes ☐ No

(l) For Full Blown Aids, please stated below appropriate condition of patient.

i. Lost of weight >10% of body weight in past 6 months ☐ Yes ☐ No

If Yes, please specify .....

ii. Kaposi Sarcoma ☐ Yes ☐ No

iii. Pneumocystis Cariini Pneumonia ☐ Yes ☐ No

iv. Progressive multifocal leukoencephalopathy ☐ Yes ☐ No

v. active Tuberculosis ☐ Yes ☐ No

vi. < 1000 lymphocytes (/μL) ☐ Yes ☐ No

vii. Malignant lymphoma ☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. HIV antibody test before & after blood transfusion, Statement from Health Authority on proof of incident, Western Blot Test, CD4 cell count test, other investigtaion blood and laboratory test)

III. Applicable for - Major Organ/Bone Marrow Transplant, or
- Chronic Aplastic Anaemia

1. (a) For Major Organ/Bone Marrow Transplant, please state full and details of condition and diagnosis that leading to the necessity of transplant surgery.

.....

(b) Which organ involved in the transplant surgery?

☐ Heart ☐ Lung ☐ Liver ☐ Kidney ☐ Pancreas ☐ Human Bone Marrow

☐ Others, please specify .....

(c) For human bone marrow transplant, please confirm whether using hematopoietic stem cells preceded by total bone marrow ablation.

☐ Yes ☐ No

(d) Has patient undergone the transplant surgery as a recipient? ☐ Yes ☐ No

If Yes, please provide details.

Date of surgery	Type of transplant	Doctor & Hospital Name

(e) Please state the prognosis of recovery?

.....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. radiological/ imaging report, Surgery report, blood and laboratory test)

2. (a) For **Chronic Aplastic Anaemia,** please stated the nature of bone marrow failure.

☐ Acute ☐ Chronic and irreversible

(b) Please confirm whether the bone marroe failure leading to below condition:

i. Anaemia ☐ Yes ☐ No

ii. Neutropenia ☐ Yes ☐ No

iii. Thrombocytopenia ☐ Yes ☐ No

iv. Others, please specify .....

(c) Was any bone marrow biopsy done to confirm the diagnosis? ☐ Yes ☐ No

If Yes, please attached a copy of the biopsy report.

If No, please state reason for bone marrow biopsy not done.

.....

(e) Was any of the following treatment given?

i. Regular blood product transfusion ☐ **Yes** ☐ **No**

If Yes, please state frequency & blood product transfused. .....

ii. Marrow stimulating agents ☐ **Yes** ☐ **No**

If Yes, please state the medications & dosage. .....

iii. Immunosuppressive agents ☐ **Yes** ☐ **No**

If Yes, please state the medications & dosage. .....

iv. Bone marrow transplantation ☐ **Yes** ☐ **No**

If Yes, please state date of surgery and name of doctor & hospital .....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. radiological/imaging report, Surgery report, blood and laboratory test)

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)