Manulife

CRITICAL ILLNESS CLAIM - ATTENDING PHYSICIAN'S STATEMENT HEART RELATED 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)

- ☐ Heart Attack/Acute Myocardial Infarction
- ☐ Serious Coronary Artery Disease
- ☐ Coronary Artery Bypass Surgery
- ☐ Angioplasty and Other Invasive Treat for Coronary Artery Disease
- ☐ Cardiomyopathy
- ☐ Primary Pulmonary Arterial Hypertension
- ☐ Heart Valve Replacement
- ☐ Surgery to Aorta

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**
- **Heart Attack/Acute Myocardial Infarction, or**
- **Serious Coronary Artery Disease, or**
- **Coronary Artery Bypass Surgery, or**
- **Angioplasty and Other Invasive Treat for Coronary Artery Disease, or**
- **Cardiomyopathy, or**
- **Primary Pulmonary Arterial Hypertension**

1. **For Heart Attack/Acute Myocardial Infarction, please provide details of investigation/ test done to confirm the diagnosis.**

Type of Investigation/Test	Date & Time	Investigation results
Cardiac enzyme marker (CK/CPKMB, Troponin T or I)		
ECG/Stress Test		
Echocardiogram		
Coronary angiogram		
Others		

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), and others)

2. **For Serious Coronary Artery Disease, Coronary Artery Bypass Surgery, Angioplasty and Other Invasive Treat for Coronary Artery Disease**

(a) **Was coronary arteriography performed** ☐ **Yes** ☐ **No**

(b) **Please indicate degree of narrowing (%) of involved artery and date of diagnosis.**

Artery	Date of diagnosis	% of narrowing
Left Main Stem (LMS)		
Left Anterior Descending Artery (LAD)		
Right Coronary Artery (RCA)		
Left Circumflex		
Others		

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(c) Please provide details of procedure/surgery performed:

Procedure/Surgery	Date & time of Surgery	Name of Surgeon	Name of hospital	Details of surgery
☐ Coronary Bypass Graft Surgery				☐ Open Chest (e.g. thoracotomy, sternotomy) ☐ Minimally invasive techniques (e.g. thoracoscopic, keyhole) ☐ Others, please specify: .....
☐ Ballon Angioplasty				
☐ Coronary Atherectomy				
☐ Laser Treatment				
☐ Keyhole Coronary Bypass Surgery				
☐ Other form				

(d) Is this the first time patient underwent any of the above procedures? ☐ Yes ☐ No

If No, please provide history of procedures done (date and type of procedures)

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Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, operation surgery report, and others)

3. For Cardiomyopathy or Primary Pulmonary Arterial Hypertension:

(a) Please stated any heart failure/cardiac impairment at present. ☐ Yes ☐ No

If Yes, please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification

☐ Class I ☐ Class II ☐ Class III ☐ Class IV

(b) Please describe in details the current limitation/physical impairment.

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.....

(c) The Cardiac impairment likely to be permanent? ☐ Yes ☐ No

(d) Details of investigation performed to confirm the diagnosis.

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(e) What is the underlying cause of cardiomyopathy/pulmonary hypertension.

☐ Coronary Artery Disease ☐ Alcohol misuse ☐ Drug abuse

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), cardiac catherization and others)

II. Applicable for - Heart Valve Replacement, or
- Surgery to Aorta

1. For Heart Valve Replacement:

(a) Please provide details of diagnosis including part of cardiac structure and type of defect involved.

.....

.....

(b) Any echocardiogram or other test done to confirm the diagnosis? ☐ **Yes** ☐ **No**

If Yes, please provide details of test results.

.....

.....

(c) Please state purpose and details of the surgery performed

☐ **Repair valvular defect(s)** ☐ **Replace damaged heart valve(s)**

Surgery date (dd/mm/yyyy)	Type of surgery	Name of surgeon	Name of hospital

(d) Please select the appropriate surgery approach.

☐ **Thoracotomy** ☐ **Key-hole** ☐ **Valvotomy** ☐ **Intra-arterial**

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), and others)

2. For Surgery to Aorta:

(a) Please state the exact location of the aortic lesion.

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.....

(b) Any echocardiogram or other test done to confirm the diagnosis? ☐ **Yes** ☐ **No**

If Yes, please provide details of test results.

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(c) The surgery was performed to correct for:

☐ **Aneurysm** ☐ **Dissection** ☐ **Obstruction**

☐ **Coarctation** ☐ **Others, please specify:** .....

(d) Please provide details of surgery:

Surgery date (dd/mm/yyyy)	Exact location of aortic lesion	Name of surgeon	Name of hospital

(e) Please select the appropriate surgery approach.

☐ **Thoracotomy** ☐ **Laparotomy** ☐ **Catheter based technique**

☐ **Key-hole** ☐ **Intra-arterial** ☐ **Laser procedure**

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), and others)

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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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