Manulife

CRITICAL ILLNESS CLAIM - ATTENDING PHYSICIAN'S STATEMENT KIDNEY, LIVER, LUNG 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)

- ☐ End Stage Kidney Failure
- ☐ Medullar Cystic Disease
- ☐ Systemic Lupus Erythematosus with Severe Kidney Complications
- ☐ End Stage Liver Failure
- ☐ Fulminant Viral Hepatitis
- ☐ Chronic Lung Disease

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)

Version 052023

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.

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

I. Applicable for - End Stage Kidney Failure, or
- Medullar Cystic Disease, or
- Systemic Lupus Erythematosus with Severe Kidney Complications

1. (a) For **CHRONIC KIDNEY FAILURE,** please confirm what is the underlying cause of illness? Please tick the relevant and provide date of onset.

☐ Lupus Nephritis Date: ..... /..... /..... (DD) (MM) (YYYY)

☐ Medullary Cystic Disease Date: ..... /..... /..... (DD) (MM) (YYYY)

☐ Diabetes Mellitus Date: ..... /..... /..... (DD) (MM) (YYYY)

☐ Inherited/Hereditary/Congenital Date: ..... /..... /..... (DD) (MM) (YYYY)

☐ Others, please specify: ..... Date: ..... /..... /..... (DD) (MM) (YYYY)

(b) What is the stage of the renal failure?

Date of renal test done (dd/mm/yyyy)	eGFR reading	Serum creatinine	Urine FEME	Others

(c) Any renal biopsy done? ☐ Yes ☐ No

(d) Please confirm whether patient's condition as below.

i. End stage renal failure? ☐ Yes ☐ No

ii. Renal failure irreversible? ☐ Yes ☐ No

iii. Renal failure is acute or chronic? ☐ Yes ☐ No

iv. Renal failure involve both kidneys? ☐ Yes ☐ No

(e) Is regular hemodialysis or peritoneal dialysis being performed? ☐ Yes ☐ No

If YES, please state the date of dialysis FIRST started. Date: ..... /..... /..... (DD) (MM) (YYYY)

(f) Has renal transplant taken place or likely to be considered in the future? ☐ Yes ☐ No

If YES, please state the date of transplantation Date: ..... /..... /..... (DD) (MM) (YYYY)

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. renal dialysis report, renal transplantation report, renal function test (eGFR, bilirubin, albumin, creatinine ratio), urine test, ultrasound/radiological report

2. (a) For **MEDULLAR CYSTIC DISEASE,** please state the clinical manifestation

☐ Anaemia ☐ Renal loss of sodium

☐ Polyuria ☐ Others, please specify: .....

(b) Any renal biopsy done? ☐ Yes ☐ No

(c) Has renal failure progress to chronic? ☐ Yes ☐ No

(d) Please state renal function, Urine FEME, imaging of kidney and other relevant test results

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Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. urine test, renal function test (eGFR, bilirubin, albumin, creatinine ratio, electrolytes), ultrasound/radiological report

3. (a) For **SYSTEMIC LUPUS ERYTHEMATOSUS,** please state the clinical manifestation.

☐ Blood ☐ Lungs

☐ Skin ☐ Kidneys

☐ Joint ☐ Others, please specify: .....

(b) Please confirm the illness with WHO Lupus Classification as below:

☐ Class I (minimal change) - Negative, normal urine

☐ Class II (Mesangial) - Moderate proteinuria, active sediment

☐ Class III (Focal Segmental) - Proteinuria, active sediment

☐ Class IV (Diffuse) - Acute nephritis with active sediment and/or nephritic syndrome

☐ Class V (Membranous) - Nephrotic Syndrome or severe proteinuria

(c) What is the stage of the renal failure?

Date of renal test done (dd/mm/yyyy)	eGFR reading	Serum creatinine	Urine FEME	Others

(d) Any renal biopsy done? ☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. renal biopsy, blood and lab test result (anti-DNA antibodies), ultrasound/radiological report, renal dialysis report, renal function test with electrolytes

II. Applicable for - End Stage Liver Failure, or - Fulminant Viral Hepatitis

1. (a) For **END STAGE LIVER FAILURE** OR **FULMINANT VIRAL HEPATITIS,** please state the sign and symptoms presented upon diagnosis?

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

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

☐ Hepatic Encephalopathy Date: ..... /..... /.....
(DD) (MM) (YYYY)

☐ Portal hypertension Date: ..... /..... /.....
(DD) (MM) (YYYY)

(b) Has liver failure progress to chronic and reached the end stage? ☐ Yes ☐ No

(c) If YES, what is the underlying cause of chronic liver failure?

☐ Viral infection ☐ Autoimmune

☐ Drug misuse ☐ Others, please specify: .....

☐ Alcohol

(d) Has the encephalopathy a form of Wernicke's encephalopathy? ☐ Yes ☐ No

(e) Is the size of liver rapidly decreasing? Please provide series of ultrasound indicating the change of size. ☐ Yes ☐ No

(f) Is there necrosis of entire liver lobules? ☐ Yes ☐ No

Please describe the extent of liver necrosis & hepatocellular damage.

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(g) Is there deterioration of liver function? Please provide series of liver function test and liver biopsy for details matter.

☐ Yes ☐ No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. liver biopsy, liver function test, hepatitis viral serology test, ultrasound/CT scan of liver, blood and laboratory test results

III. Applicable for - Chronic Lung Disease

1. (a) Has the lung disease reached end stage? Please stated date of diagnosis.

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

(b) What is the underlying cause of respiratory failure?

☐ Asthma
☐ COPD
☐ Chronic bronchitis
☐ Tuberculosis
☐ Pulmonary fibrosis
☐ Others, please specify: .....

(c) Did the patient required permanent or temporary oxygen therapy for respiratory failure?

☐ Permanent ☐ Temporary

(d) Is there any dyspnoea at rest? ☐ Yes ☐ No

(e) Please provide details of lung function test done (including date and result).

Lung Function Test	Date:	Date:	Date:	Date:
FEV1				
FVC				
Others				

(f) Please provide details of all arterial blood gas (ABG) analysis done (including dates and results)

Arterial Blood Gas Analysis	Date:	Date:	Date:	Date:
PaO2				
PaCO2				

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT scan of lung, blood and laboratory test results, other imaging report, lung function test, arterial blood gas 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)

Version 052023