Manulife

TOTAL AND PERMANENT DISABILITY CLAIM - DOCTOR STATEMENT

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

Patient's Personal Details

Policy No.	**1)**
	2)
	3)
	4)
Name of Patient	
New NRIC/Old IC No.	
Date of Birth	
Gender	

A PATIENT'S MEDICAL RECORD

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

2. Did the patient previously 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, pre-malignant condition, cancer or any other significant illnesses?

☐ **Yes** ☐ **No**

If "Yes", please provide following details:

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

3. Date when patient FIRST consulted you for the illness/condition.	**Date:** ..... /..... /..... (DD) (MM) (YYYY)

4. 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:** .....

Version 052023

5. (a) Please provide below details if the condition due to **ACCIDENT.**

Date & Time of Accident	Place of Accident	Details of Accident

(b) Was patient under influence of alcohol/drug at the time of accident? ☐ Yes ☐ No

If Yes, please specify details .....

(c) Was the condition related to self-inflicted whether sane or insane? ☐ Yes ☐ No

If Yes, please specify details .....

6. Please describe the full and exact diagnosis with diagnosis date.

Diagnosis Date	Details of diagnosis

7. Please provide type of investigation and test done to confirm the diagnosis.

Date	Type of investigation/test	Results

8. Please provide type of treatment/ medication given and patient's response on the treatment

Date	Type of treatment. edication given	Response on the treatment

9. Date when patient **LAST** consulted you for the illness/condition. Date: ..... /..... /.....
(DD) (MM) (YYYY)

10. The presenting signs and symptoms during LAST consultation with you.

.....

11. Please describe patient's occupation and nature of duties prior to disability

.....

12. Date when patient **FIRST** unable attend to work due to disability Date: ..... /..... /.....
(DD) (MM) (YYYY)

13. How does the disability prevent patient from performing above listed nature of work?

.....

.....

14. Please describe patient's current state of mobility.

☐ Ambulatory without aid
☐ Ambulatory with aid. Please specify .....
☐ Home confined
☐ Hospital confined
☐ Wheelchair bound
☐ Bed-ridden

15. Was patient currently undergoing any form of rehabilitation (e.g. retraining, physiotherapy)?

☐ Yes ☐ No

If Yes, please specify .....

16. Please stated progress of recovery as below.

☐ Recovered ☐ Static ☐ Improving ☐ Deteriorating

17. Physical and Neurological Assessment:-

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

(a) Vision (Visual Acuity)

	Left	Right
Normal		
Impaired		
Scores based on metric activity		

Remarks: .....

(b) Hearing (based on audiometry results)

	Left	Right
Normal		
Impaired		
Scores based on speech reception threshold		

Remarks: .....

(c) Speech function

☐ Clear and understandable ☐ Slurred ☐ Unable to speak

Remarks: .....

(d) Cognitive function

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

Remarks: .....

(e) General examination:

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

(f) Examination of muscle power and range of movement of limbs with maximum grade of 5 being the highest and 0 being the lowest.

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

Remarks: .....

(g) Activities of Daily Living Assessment:

Activities of Daily Living	Not Limited	Limited	Incapable	Description
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				

18. Please evaluate current working capacity of patient based on current health condition.

- ☐ Incapable of light manual duties (e.g. slight restriction on mobility) Please specify .....
- ☐ Incapable of heavy manual duties (e.g. moderate restriction on mobility) Please specify .....
- ☐ Incapable of sedentary manual duties (e.g. severe restriction on mobility) Please specify .....

19. Please provide details of patient's ability to perform an occupation.

Condition	Own occupation	Other occupation
(a) Was patient currenly total disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) i. Do you expect fundamental/significant change of present condition in near future? ii. If Yes, when will be patient expected resume to work Please specify nature of work for other occupation.	☐ Yes ☐ No	☐ Yes ☐ No

20. Was patient physically or mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

If Yes, please specify details with date of such disability commence.

.....

21. (a) For Juvenile less than 16 years old, please confirmed whether patient confined to hospital or any healthcare facility/home under medical supervision.

☐ Yes ☐ No

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

(b) Please provide in details type of treatment/ care rendered during confinement.

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

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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 Doctor

Name & practice stamp

Name & address of clinic/hospital

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

Version 052023