Manulife Financial

Group Benefits
Critical Illness
Attending Physician's Statement - Blindness

- *Use this form to provide details of the condition or disease for the person identified in Section 1 as the patient. To allow us to assess this claim, all questions must be answered in full. This information will be used to make decisions about any benefits payable. Regrettably, incomplete forms compromise our ability to reach a decision.*
- *In this document,* we, us, *and* our *refer to The Manufacturers Life Insurance Company.*

Please print clearly.

1 a) Personal information

Section 1 a) must be completed by the plan member.

Plan contract number	Certificate number	Plan member name (first, middle initial, last)	
Patient name		Patient date of birth (dd/mmm/yyyy)	
Address	City	Province	Postal code

1 b) Authorization to release personal information

Section 1 b) must be signed and dated by the patient or the patient's representative if the patient is under the age of 16 or incompetent.

I hereby authorize the release to Manulife Financial of any medical information in my file including, but not limited to, copies of consultation reports, clinical notes, test results and hospital records for the purpose of administering the group plan and assessing my claim. I understand that I am responsible for any fees related to the completion of this form.

Signature of patient or patient's legal representative if patient is under the age of 16 or incompetent (attach applicable documents)	Date (dd/mmm/yyyy)

2 a) Medical information

All of Section 2 must be completed, signed and dated by the **physician**.
Please answer all questions completely or indicate **n/a**.

1. When did your patient first consult you for any eye problem? Date (dd/mmm/yyyy) — How long has this person been your patient? Date (dd/mmm/yyyy)

   Are you this person's regular treating physician? ◯ Yes ◯ No

   If "No," please provide the full name and address of this patient's usual medical attendant.

Name	Telephone number ( )
Address (number, street and suite)	
City / Province / Postal code	

2. On what date did your patient first suffer symptoms or become aware of any eye problem? Please provide details.

3. What is the corrected vision or the field of vision in each eye?

   On what date was this test performed? Date (dd/mmm/yyyy)

   Please provide the name and address of the opthamologist.

Name			
Address (number, street and suite)	City	Province	Postal code

2 a) Medical information *(continued)*

What is the cause of the blindness?

Is the blindness permanent?

Is there any treatment that could improve your patient's vision?

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related condition.

Name of physician or hospital	**Address** (number, street, city, province, postal code)	**Date from** (dd/mmm/yyyy)	**Date to** (dd/mmm/yyyy)

5. Please describe, including dates, any predisposing disorders or risk factors that your patient had for blindness.

6. Is there a family history of eye disorders? Please provide details.

Please provide details of any other significant family history.

7. Does your patient use any form of tobacco, marijuana, nicotine products or nicotine substitutes? ◯ Yes ◯ No

If "Yes," please indicate amount per day. How long has the patient used these?

If "No," did the patient previously use any of these? ◯ Yes ◯ No

On what date did the patient quit? Date (dd/mmm/yyyy)

8. Please provide any other information that would be helpful in the assessment of your patient's claim.

Please provide copies of your consultation notes, specialist or hospital reports, current x-rays, tests/investigations, laboratory data and any clinical findings.

2 b) Physician's authorization

Note: The patient is responsible for paying any fee charged for completion of this Attending Physician's Statement.

The information in this statement will be kept in a group life, health and/or disability benefits file with Manulife Financial and may be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, you consent to such unedited release of any information contained herein.

Attending physician (please print)

Certified specialist		Telephone number ( )	
Address	City	Province	Postal code
Signature		Date signed (dd/mmm/yyyy)	

3 Mailing instructions

Please mail the completed form to: **Halifax Group Disability Claim Office**
PO Box 1030, Stn Central
HALIFAX NS B3J 2X5
1-800-565-0627
(902) 453-4300
(902) 429-7292 1-866-292-9050