Manulife Financial

# Group Benefits
# Critical Illness
## Attending Physician's Statement - Heart Attack

- *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 this condition? Date (dd/mmm/yyyy) ____ How long has this person been your patient? ____

   Was a diagnosis of myocardial infarction made? ◯ Yes ◯ No

2. On what date was the diagnosis made? Date (dd/mmm/yyyy) ____

   By whom was the diagnosis made?

   Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this heart attack.

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

3. Please provide the following details pertaining to the insured's myocardial infarction.
   Description and date of onset of chest pain

   ECG changes in detail at time of event or provide copies of all ECG tracings, if available

   Cardiac enzyme levels, including CPK – MB fraction and percentage of total CPK at time of diagnosis (please provide copies of all test results)

## 2 a) Medical information *(continued)*

Cardiac biochemical marker levels (please provide copies of all test results)

Are any elevations in cardiac enzyme or cardiac biochemical marker levels due to coronary angioplasty? If so, please elaborate in relation to ECG changes.

Has a previous ECG been performed? ◯ Yes ◯ No If "Yes," please provide copies.

4. What other investigations have been performed? Please provide dates and details, or reports.

5. When did your patient first suffer symptoms or episodes of cardiovascular disease? Please provide details and dates.

6. Please describe, including dates, any predisposing conditions or risk factors which your patient has had for cardiovascular disease. (i.e. high B/P, high cholesterol, chest pain, diabetes or other pre-cursors to heart disease)

7. Is there a family history of cardiovascular disease or cerebrovascular disease? Please provide details.

8. 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)

9. 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**