

## Group Benefits Critical Illness

### Attending Physician's Statement - Occupational HIV Infection

- 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)
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#### 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. Are you this patient's usual medical attendant?  Yes  No

If "Yes," please provide copies of your office records, investigations performed, consultation reports and hospitalization summaries for the past 5 years.

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 were you first consulted for this condition?

3. How long had symptoms been present?

3. Please provide dates of all HIV or antibody tests performed, and the results of these.

Date (dd/mmm/yyyy)	Results
Date (dd/mmm/yyyy)	Results

4. On what date was the patient first diagnosed as HIV positive?

5. What treatment has been offered?

<input type="text"/>
<input type="text"/>

Was it taken?  Yes  No

6. Please provide full details of the method of transmission, including the date and where it took place.

<input type="text"/>
<input type="text"/>

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

7. Was the incident reported in accordance with established occupational procedures?  Yes  No  
If "Yes", please provide details of where this was reported. (Copies of any available reports would be appreciated)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Please give details of anything in the patient's habits, personal medical history or family history which would have increased the risk or contributed to their condition.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. 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) \_\_\_\_\_

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

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

11. 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)

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

Please mail the completed form to: **Critical Illness Claims  
Group Benefits Manulife Financial  
PO BOX 395 SUCC PLACE D'ARMES  
MONTREAL QC H2Y 3H1**  
Telephone: 1-866-236-6313  
(514) 288-6268  
Fax: 1-888-488-6738  
(514) 286-6738