Manulife Financial

Group Benefits
Critical Illness
Attending Physician's Statement - Heart Valve Replacement

- *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. How long has this person been your patient?

2. 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	

When did your patient first suffer symptoms or episodes of coronary artery disease? What were they?

Date (dd/mmm/yyyy)	Symptoms

When was a heart murmur first detected?	Date (dd/mmm/yyyy)	On what date did your patient first consult you for these symptoms?	Date (dd/mmm/yyyy)

3. Please provide all angiography and echocardiogram reports.

4. Please give details of the valve replacement surgery.

Date of operation (dd/mmm/yyyy)	Which valves were replaced?		
Name of hospital	Date from (dd/mmm/yyyy)	Date to (dd/mmm/yyyy)	
Address of hospital (number, street)	City	Province	Postal code
Name of operating surgeon			
Address of operating surgeon (number, street and suite)	City	Province	Postal code

2 a) Medical information *(continued)*

5. Name and address of the cardiologist recommending the valve replacement.

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

6. Please describe, including dates, any predisposing conditions or risk factors that your patient had for cardiovascular disease.

7. 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)

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

9. Please provide details of anything in the patient's lifestyle or habits or personal medical history which would have increased the risk or contributed to your patient's diagnosis:

10. 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)

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)			
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