Manulife Financial

Group Benefits
Critical Illness
Attending Physician's Statement - Paralysis or Loss of Use of Limbs

- *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. Please provide a brief outline of the medical history leading to your patient's paralysis or loss of use of limbs.

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

Are you this patient's usual medical attendant? ◯ 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. When did your patient first consult you for this condition? Date (dd/mmm/yyyy)

3. If paralysis was a result of an accident please provide details.

4. Which limbs are affected?

Provide details of the exact loss of function.

Describe residual use, if any, of the patient's affected limbs.

If paralysis or loss of use was not a result of an accident, when did your patient first suffer symptoms or become aware of this condition? What is the underlying cause of the condition?

2 a) Medical information *(continued)*

Have there been any signs of improvement during the 90 days following the precipitating event of this condition? ◯ Yes ◯ No

If "Yes," please elaborate:

5. Is the condition permanent without any likelihood of recovery? ◯ Yes ◯ No
6. Are there any treatments that could significantly improve the condition?
7. 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)

8. Please provide the results of all relevant investigations.
9. Are you aware of any member of your patient's close family who has suffered from the same or similar underlying cause?

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 1-800-565-0627
PO Box 1030, Stn Central (902) 453-4300
HALIFAX NS B3J 2X5 (902) 429-7292 1-866-292-9(