

Group Benefits Critical Illness

Attending Physician's Statement - Parkinson's Disease

- 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. On what date did your patient first have symptoms? Date (dd/mmm/yyyy)

When did your patient first consult you for this condition? Date (dd/mmm/yyyy)

On what date was the diagnosis of possible Parkinson's disease first discussed with the patient? Date (dd/mmm/yyyy)

When was your patient first given a firm diagnosis of idiopathic Parkinson's disease? Date (dd/mmm/yyyy)

Please provide the name and address of the neurologist who confirmed the diagnosis.

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

2. 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) |
|-------------------------------|--|----------------------------|--------------------------|
| | | | |
| | | | |
| | | | |

3. Please outline the clinical course and describe the patient's neurological signs and symptoms, giving dates and duration.

4. Did Parkinson's disease result from treatment for any other illness, or is it associated with any other disease? (i.e., atherosclerosis, supranuclear palsy) Yes No

Did features of Parkinson's disease occur as a side effect of any prescribed drug therapy or illicit drug use? Yes No

Please provide details.

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

5. Please give details of current treatment.

6. Does your patient have any trouble with any of the following?

| | | | | | |
|----------|---------------------------|--------------------------|--------------|---------------------------|--------------------------|
| Bathing | <input type="radio"/> Yes | <input type="radio"/> No | Toileting | <input type="radio"/> Yes | <input type="radio"/> No |
| Eating | <input type="radio"/> Yes | <input type="radio"/> No | Transferring | <input type="radio"/> Yes | <input type="radio"/> No |
| Dressing | <input type="radio"/> Yes | <input type="radio"/> No | | | |

7. Has your patient previously suffered from any predisposing disorders? Yes No
If "Yes," please provide details.

8. Is there a family history of Parkinson's disease? Yes No
If "Yes," please provide details.

9. Is there any other significant family history?

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: **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**