Manulife Financial

Group Benefits
Critical Illness
Attending Physician's Statement - Stroke

- *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 (first, middle initial, last)	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 consult you for this condition? — Date (dd/mmm/yyyy) | How long has the insured person been your patient?

2. Has there been thrombosis, hemorrhage or embolism from an extra-cranial source? ◯ Yes ◯ No

   Was a diagnosis of Cerebrovascular Accident made? ◯ Yes ◯ No

   On what date did the CVA occur? Date (dd/mmm/yyyy)

   Please describe the cause of the CVA.

   Please describe the residual neurological deficits.

   How long have the neurological deficits persisted?

   By whom was the diagnosis made?

Please provide a copy of the CT Scan or MRI if available.

3. On what date was the patient advised of the diagnosis? — Date (dd/mmm/yyyy) | By whom?

2 a) Medical information *(continued)*

4. Please provide the names and addresses of other physicians consulted or hospitals attended by your patient for this stroke or CVA.

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

What other investigations have been performed? Please provide details.

5. On what date did your patient first have symptoms or episodes of cerebrovascular disease? Date (dd/mmm/yyyy)

What were the symptons?

6. Please describe, including dates, any predisposing disorders or risk factors or any history of cardiac disease or disorder.

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