Manulife Financial

Group Benefits
Critical Illness
Attending Physician's Statement - Major Organ or Bone Marrow Transplant

- *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 indicate your diagnosis. Specify organ(s).

Is this condition the result of (check one)

◯ an accident ◯ disease ◯ degenerative process

Please provide complete details of the disorder leading to your patient's transplant procedure.

On what date did your patient first suffer symptoms of this disorder? What were the symptoms?

Date (dd/mmm/yyyy)	Symptoms

On what date was the disorder first diagnosed?	Date (dd/mmm/yyyy)	On what date was your patient enrolled in a transplant program?	Date (dd/mmm/yyyy)
Where is the program being conducted?		How long has this person been your patient?	

2. How long had end stage disease been present?

3. Please provide details of the transplant procedure performed, including the name and address of the hospital, the attending surgeon/physician and the date of the procedure.

Name of hospital	Date from (dd/mmm/yyyy)	Date to (dd/mmm/yyyy)

Address of hospital (number, street)	City	Province	Postal code

Name of surgeon

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

Details of the transplant procedure

2 a) Medical information *(continued)*

4. If the organ in question was the pancreas, was the procedure performed a transplantation of islet cells? ◯ Yes ◯ No

5. Please describe, including dates, any predisposing disorders or risk factors the patient had for the underlying disorder.

6. Please give 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)

7. Is there anything in your patient's habits or family history that increased the risk for the underlying disorder? If so, please provide details.

Please provide details of any other significant family history.

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 give details if there is a history of sickle cell disorders, thalassemia, hepatitis B or other haemoglobinopathy or cirrhosis.

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