Manulife Financial

Group Benefits
Critical Illness
Attending Physician's Statement - Loss of Speech

- *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. Are you this patient's usual medical attendant? ◯ Yes ◯ No

   If "Yes," please provide copies of your office records, investigations performed, consultation reports and hospitalization summaries for the past five years.

   If "No," please provide the full name and address of this patient's usual medical attendant.

Name of attending physician	Telephone number ( )
Address (number, street and suite)	
City / Province / Postal code	

2. On what date did your patient first consult you for loss of speech? Date (dd/mmm/yyyy) ____ How long has the insured person been your patient? ____

3. On what date did your patient first have symptoms or become aware of loss of speech? Please provide details.

Date (dd/mmm/yyyy)	Details

4. Please provide details, including dates of the injury or disease causing loss of speech.

   Is the loss of speech permanent and irreversible? ◯ Yes ◯ No

   Please describe the degree of loss of speech.

5. Were there any associated neurological or psychological complications including hysterical asphonia?

   Did this condition result from any other factors such as a stroke, tumour, cancer or other condition? Did the incident/surgery result from ingestion of drugs (prescribed or not prescribed), alcohol or intravenously introduced substance? If "Yes," please provide details.

2 a) Medical information *(continued)*

6. Please indicate duration and frequency of any speech therapy sessions.

7. Has there been any improvement in the patient's speech since the onset of the condition?

8. What investigations or tests have been performed to verify the diagnosis of permanent loss of speech?

9. Has your patient suffered any previous episodes of loss of speech or any condition leading or related to it?

10. Please give full details of anything in the patient's habits or personal medical history which would have increased the risk of loss of speech.

11. Please give full details of anything in the patient's family history that would have been a contributing factor.

12. Please give the names and addresses of other physicians or speech language therapists 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)

13. 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)

14. 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