Manulife Financial

Group Benefits
Critical Illness
Attending Physician's Statement - Major Organ Transplant Waiting List

- *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).
2. Please indicate the date symptoms of organ failure first appeared. Date (dd/mmm/yyyy)
3. Is this condition the result of (check one)
   ◯ an accident ◯ disease ◯ degenerative process
4. Please give the clinical diagnosis and the onset date of this primary condition.
   Diagnosis
   Date (dd/mmm/yyyy)
5. What tests were conducted to arrive at the diagnosis of organ failure?
6. Has your patient been placed on a Canadian or U.S. waiting list for organ transplantation? ◯ Yes ◯ No
   If "Yes," at which facility and when was he/she added to the list?
   Name of facility | Date (dd/mmm/yyyy)
7. On what date was your patient advised on when he or she was added to the waiting list? Date (dd/mmm/yyyy)
8. If surgery has been done, please provide the following details.
   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
   Type of transplant surgery
9. Please provide documentation of the history of end stage heart, kidney, lungs, liver or bone marrow disease preceding surgery.

2 a) Medical information *(continued)*

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

11. Is there anything else in this patient's past history or family history that contributed to this condition?

12. 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

Telephone number ( )

Address (number, street and suite)

City

Province

Postal code

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 names and addresses of all consultants, specialists or hospitals to which your patient has been referred to or attended 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)

15. 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
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