

CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Cancer

Note: This form is to be completed at the Patient's expense by the Attending Physician/ Surgeon who treated the patient.



Patient's Personal Details

Name		Policy Number	
<input type="text"/>		<input type="text"/>	
NRIC/Old IC/Passport/Birth Cert/Others	Date of Birth	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female

The claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

Sections to be completed		Sections to be completed	
<input type="checkbox"/> Cancer/ Early Stage Cancer	A, B, C, & D	<input type="checkbox"/> Mastectomy For Carcinoma-In-Situ Breast	A, B, C, & D
<input type="checkbox"/> Carcinoma-in-situ (Breast/ Cervix Uteri/ Uterus/ Ovary/ Fallopian Tube/ Vagina)	A, B, C, & D	<input type="checkbox"/> Prostatectomy For Stage 1 Prostate Cancer	A, B, C, & D
		<input type="checkbox"/> Cystectomy For Carcinoma-In-Situ Urinary Bladder/ Papillary Carcinoma Of The Bladder	A, B, C, & D

Note: Assessment of claims and provision of benefits will be based on the Policy mentioned in this form.

SECTION A : Medical Record of the Patient

1. Are you the patient's regular/ family doctor?
 YES NO

If Yes, over what period do your records extend?
 Day Month Year

2. Date the patient first consulted you for this illness / injury.
 Day Month Year

3. The presenting signs and symptoms.

4. The date when the patient first noticed the presenting signs and symptoms.
 Day Month Year

5. In your opinion, how long have the presenting signs and symptoms lasted prior to the first consultation with you?
 Day Month Year

6. Please describe the full and exact diagnosis and treatment advice was given.

Diagnosis Date (DD/MM/YYYY)	Diagnosis	Treatment Advice
<input type="text"/>	<input type="text"/>	<input type="text"/>

7. Date when the patient was informed of the diagnosis.
 Day Month Year

8. Which of the following factors are present? For factors which are present, please provide the date of onset.

i. Hypertension YES NO Day Month Year

ii. Diabetes Mellitus YES NO Day Month Year

iii. Hyperlipidemia YES NO Day Month Year

iv. Others, please specify
 Day Month Year

SECTION B

- Cancer/ Early Stage Cancer
- Carcinoma-In-Situ (Breast/ Cervix Uteri/ Uterus/ Ovary/ Fallopian Tube/ Vagina)

- Mastectomy For Carcinoma-In-Situ Breast
- Prostatectomy For Stage 1 Prostate Cancer
- Cystectomy For Carcinoma-In-Situ Urinary Bladder/ Papillary Carcinoma Of The Bladder

1. Was biopsy done? If Yes, please attach histopathology report.

YES NO

If No, please provide the reason of biopsy not performed.

2. Was imaging done?

YES NO

If Yes, please provide the details & attach all imaging reports.

3. For Female Cancer only.

a. Has the patient undergone PAP smear?

YES NO

If Yes, please provide date of the latest smear done.

Day Month Year

b. Did the patient's earlier smear show abnormal results?

YES NO

If Yes, please provide the details on the following.

Date (DD/MM/YYYY)	Smear Test Result

4. The applicable staging system of the tumour (E.g. TNM, FIGO, AJCC, Ann Arbor's, Duke's etc).

5. It is classified as: (Please tick [✓] in the appropriate box)

- | | |
|---|---|
| <input type="checkbox"/> Pre-Malignant
<input type="checkbox"/> Non-Invasive
<input type="checkbox"/> Carcinoma-In-Situ | <input type="checkbox"/> Having Borderline Malignancy
<input type="checkbox"/> Having Malignant Potential
<input type="checkbox"/> Malignancy |
|---|---|

6. Please confirm on the following. If Yes, please provide the details.

a. Was the cancer completely localized?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
b. Was there invasion of tissues?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
c. Were regional lymph nodes involved?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
d. Was there distant metastasis?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

7. Is the diagnosis falling within any of the following condition(s)?

- | | | |
|---|------------------------------|-----------------------------|
| a. T1N0M0 Urinary Bladder Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Papillary Carcinoma of bladder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Malignant Melanoma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| d. Skin Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| e. Stage 1 Hodgkin's Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| f. Tumours manifesting as complications of AIDS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| g. Stage 1 Prostate Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| h. T1N0M0 Thyroid Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| i. Chronic Lymphocytic Leukemia less than RAI stage 3 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If Yes, please provide the details.
(E.g. Type of Tumour, RAI staging, Breslow classification, etc.)

8. What is the nature of treatment?

Treatment	Date (DD/MM/YYYY)	Type and Details
Surgery		
Radiotherapy		
Chemotherapy		
Others, please specify.		

Please attach certified true copies of all relevant reports (E.g. Histopathology examination (HPE)/Biopsy report, Blood and Laboratory test results, Bone marrow aspiration / trephine biopsy report, Surgical Report, Radiological report, CT Scan, Imaging report, etc.)

9. Is the cancer condition related to the exposure of radioactive substance or radiation?

YES NO

If Yes, please provide the details.

SECTION C : Others Medical Information

1. Has the patient previously suffered from this illness or any related illness or any other illnesses?

YES NO

If Yes, please provide details as required below :

Date of Consultation (DD/MM/YYYY)	Illness/ Diagnosis	Types of Treatment Received/ Details of Hospitalisation	Investigation Result	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

2. Was the patient referred to you?

YES NO

If Yes, please provide details below and enclose a copy of the referral letter (if any):

Name & Address of Referral Doctor

SECTION D : Attending Doctor's Declaration

I hereby certify that:

I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR

I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature : _____ Date : _____

Name : _____

Professional Qualification : _____

MMC/ Registration Number : _____

Name & Address of Hospital/ Clinic : _____

Official Stamp of the Doctor : _____