PREGNANCY COMPLICATIONS CLAIM - DOCTOR'S STATEMENT

Note: This form is to be completed by the Attending Doctor at the Patient's expense

PRUDENTIAL

Patient's Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Other

Date of Birth

Gender ☐ Male ☐ Female

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

	Section to be completed:
☐ Abruptio Placentae	A, B & P
☐ Acute Fatty Liver of Pregnancy Amniotic	A, C & P
☐ Fluid Embolism	A, D & P
☐ Death of Foetus	A, E & P
☐ Death of the Life Assured's Child	A, F & P
☐ Disseminated Intravascular Coagulation	A, G & P
☐ Eclampsia	A, H & P

	Section to be completed:
☐ Ectopic Pregnancy	A, I & P
☐ Gestational Diabetes Mellitus	A, J & P
☐ Hydatidiform Mole	A, K & P
☐ Late Miscarriage	A, L & P
☐ Postpartum Haemorrhage Requiring Hysterectomy	A, M & P
☐ Pre-Eclampsia	A, N & P
☐ Pulmonary Embolism of Pregnancy	A, O & P

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

SECTION A : Medical History of the Patient

1. Are you the patient's usual Medical Attendant?

☐ YES ☐ NO

2. Over what period do your records extend?

i) 1st consultation ☐ Day ☐ Month ☐ Year

ii) Last consultation ☐ Day ☐ Month ☐ Year

3. What were the symptoms presented when you first attended the patient? How long had the patient been experiencing the symptoms when you first saw the patient?

Symptom(s)	Duration of Symptom(s)

4. Date when the patient first became aware of the condition(s).

☐ Day ☐ Month ☐ Year

5. Please provide the full and exact details of diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

7. Date when the patient was informed of the diagnosis.

☐ Day ☐ Month ☐ Year

8. Name and practice of doctor(s) who first diagnosed the patient.

9. Please provide the dates and other details of investigations performed.

Date (DD/MM/YYYY)	Test / Laboratory / Imaging

10. Is the diagnosis related to any of the following? (Please tick [✓] and circle the relevant option)

- ☐ Pregnancy results from fertility treatment, including in-vitro fertilisation
- ☐ Chosen to have a termination of pregnancy other than for medical reasons
- ☐ Alcohol or Substance Abuse/Addiction
- ☐ AIDS / HIV Positive
- ☐ Violation of laws / Strike / Riots
- ☐ Suicide/ Self-inflicted injury or self-inflicted illness
- ☐ Injuries or sickness arising from professional sports, racing of any kind, scuba-diving, aerial sport activities
- ☐ Nuclear fusion, nuclear fission, nuclear waste or any radioactive or ionizing radiation.
- ☐ Psychotic / Mental / Nervous / Sleeping Disorder

SECTION G ▪ Disseminated Intravascular Coagulation

1. Was there entrance of uterine material with tissue factor activity into the maternal circulation?
   ☐ YES ☐ NO
2. Please describe the details of the resulting microvascular thrombosis and major haemorrhage, if present.
3. Please clarify which month / week of pregnancy was Disseminated Intravascular Coagulation first diagnosed?
4. What was the treatment given?
5. Does the treatment mentioned above include lists below:
   i) Frozen plasma ☐ YES ☐ NO
   ii) Unexplained coma ☐ YES ☐ NO
6. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

SECTION H ▪ Eclampsia

1. Does the patient have signs and symptoms of pre-eclampsia?
   ☐ YES ☐ NO
2. Does the patient have the listed conditions below during pregnancy or shortly after delivery:
   i) Grand Mal seizures ☐ YES ☐ NO
   ii) Unexplained coma ☐ YES ☐ NO

SECTION I ▪ Ectopic Pregnancy

1. Please describe or provide the location where the implantation of a fertilised ovum had occurred outside the uterine cavity.
2. Please provide details on how the ectopic pregnancy was confirmed.
   Kindly furnish us with a copy of the test results confirming the diagnosis.
3. Was there any surgery perform to terminate the ectopic pregnancy?
   ☐ YES ☐ NO

   If Yes, kindly provide the Date of Surgery.
   ☐ Day ☐ Month ☐ Year

   The type of surgery performed is:
   ☐ Laparotomy
   ☐ Laparoscopic

   Was the surgery:
   ☐ Emergency
   ☐ Elective

   If no, what was the treatment given?
4. What were the operative findings?
   Kindly furnish us with a copy of the histopathology examination report.

SECTION J ▪ Gestational Diabetes Mellitus

1. Did the patient have Diabetes Mellitus during pregnancy?
   ☐ YES ☐ NO
2. Please provide Oral Glucose Tolerance Test (OGTT) where venous plasma glucose 2 hours after 75 gram oral glucose.
3. What was the treatment given?
4. Name of doctor and speciality.

SECTION K ▪ Hydatidiform Mole

1. Is the pregnancy at the end stage and degenerating?
   ☐ YES ☐ NO
2. Please provide details on how the Hydatidiform Mole, whereby the chorionic villi has formed vesicles that resembles a bunch of grapes, was confirmed.

   Kindly furnish us with a copy of the histopathology examination report.
3. Is trophoblastic hyperplasia present and proven?
   ☐ YES ☐ NO

SECTION L ▪ Late Miscarriage

1. Please clarify how the Late Miscarriage was diagnosed.
   Kindly furnish us with a copy of the test results confirming the diagnosis.
2. Please state the number of weeks of gestation for complete expulsion or extraction of the Life Assured's foetus from the Life Assured.
3. Please provide details on how the death of foetus was confirmed.

SECTION M ▪ Postpartum Haemorrhage Requiring Hysterectomy

1. Please clarify cause of Postpartum Haemorrhage.
   ☐ Unresponsive and atonic uterus
   ☐ Ruptured uterus
   ☐ Large cervical laceration extending into the uterus
   ☐ None of the above, please specify
2. Was there any procedure/surgery performed for Postpartum Haemorrhage?
   ☐ YES ☐ NO

   If Yes, kindly provide the Date of Surgery
   ☐ Day ☐ Month ☐ Year
3. Kindly specify the type of procedure/surgery done.

SECTION N ▪ Pre-Eclampsia

1. Did the patient have pregnancy induced hypertension?

   ☐ YES ☐ NO

   If yes, kindly provide details of patient BP reading & result of protein in urine.
   Kindly furnish us with a copy of the test results confirming the diagnosis.

2. Please state the number of weeks of gestation when the patient first diagnosed with Pre-Eclampsia.

SECTION O ▪ Pulmonary Embolism of Pregnancy

1. Did the patient have Pulmonary Embolism during pregnancy?

   ☐ YES ☐ NO

2. ***Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.***

Please utilise the blank space below to provide any additional information regarding the patient's condition.

SECTION P : Attending Doctor's Declaration

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient; 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.

If you are not the attending doctor, please state:

The Attending Doctor's Name & Speciality:

The reason(s) for completing the above mentioned information on behalf of the Attending Doctor:

Signature of Doctor :

Date :

Name :

Professional Qualification :

Name & address of hospital/ clinic :

Hospital's/ Doctor's Stamp :

Prudential Assurance Malaysia Berhad (107655-U)
Level 17, Menara Prudential, No. 10, Jalan Sultan Ismail,50250 Kuala Lumpur. P.O. Box 10025,50700 Kuala Lumpur.
Customer Service Hotline: 603-2116 0228, Fax: 603-2032 3939, E-mail: customer.mys@prudential.com.my