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.

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender ☐ Male ☐ Female

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

	Sections to be completed
☐ Cancer	A, B, C, & D
☐ Early Stage Cancer (Prostate/Thyroid/Bladder/CLL/Melanoma)	A, B, C, & D
☐ Carcinoma-in-situ (Breast/Cervix Uteri/Uterus/Ovary/Tube/ Fallopian Tube/ Vagina)	A, B, C, & D
☐ Hysterectomy (Corpus Uteri)	A, B, C, & D
☐ Salpingectomy (Fallopian tube)	A, B, C, & D
☐ Oopherectomy (Ovary)	A, B, C, & D

	Sections to be completed
☐ Mastectomy For Carcinoma-In-Situ Breast	A, B, C, & D
☐ Prostatectomy For Stage 1 Prostate Cancer	A, B, C, & D
☐ Partial Colectomy with End-to-end Anastomosis	A, B, C, & D
☐ Partial Gastrectomy with End-to-end Anastomosis	A, B, C, & D
☐ 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

M. 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

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

FORM ID 11601121

SECTION B

- **Cancer/ Early Stage Cancer / Carcinoma-In-Situ**
- **Hysterectomy (Corpus Uteri)**
- **Salpingectomy (Fallopian tube)**
- **Oopherectomy (Ovary)**
- **Partial Colectomy with End-to-end Anastomosis**
- **Mastectomy For Carcinoma-In-Situ Breast**
- **Prostatectomy For Stage 1 Prostate Cancer**
- **Cystectomy For Carcinoma-In-Situ Urinary Bladder/ Papillary Carcinoma Of The Bladder**
- **Partial Gastrectomy with End-to-end Anastomosis**

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)

☐ Pre-Malignant
☐ Non-Invasive
☐ Carcinoma-In-Situ
☐ Having Borderline Malignancy
☐ Having Malignant Potential
☐ Malignancy

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

a. Was the cancer completely localized?	☐ YES ☐ NO	
b. Was there invasion of tissues?	☐ YES ☐ NO	
c. Were regional lymph nodes involved?	☐ YES ☐ NO	
d. Was there distant metastasis?	☐ YES ☐ NO	

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

			If Yes, please provide the details. (E.g. Type of Tumour, RAI staging, Breslow classification, etc.)
a. T1N0M0 Urinary Bladder Cancer	☐ YES	☐ NO	
b. Papillary Carcinoma of bladder	☐ YES	☐ NO	
c. Malignant Melanoma	☐ YES	☐ NO	
d. Skin Cancer	☐ YES	☐ NO	
e. Stage 1 Hodgkin's Disease	☐ YES	☐ NO	
f. Tumours manifesting as complications of AIDS	☐ YES	☐ NO	
g. Stage 1 Prostate Cancer	☐ YES	☐ NO	
h. T1N0M0 Thyroid Cancer	☐ YES	☐ NO	
i. Chronic Lymphocytic Leukemia less then RAI stage 3	☐ YES	☐ NO	

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.

10. Is the cancer condition newly diagnosed or recurrent case?

☐ New diagnosis ☐ Recurrent diagnosis

If this is recurrent case, please provide the following details in the table.

Diagnosis Date (DD/MM/YYYY)	Final diagnosis	Treatment(s)

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 :

Name :

Professional Qualification :

MMC/ Registration Number :

Date :

Name & Address of Hospital/ Clinic :

Official Stamp of the Doctor :

FORM ID 11601121