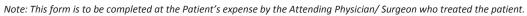
CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT







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	Sections to be completed							
Cancer A, B, C, & D Mastectomy I	For Carcinoma-In-Situ Breast A, B, C, & D							
	y For Stage 1 Prostate Cancer A, B, C, & D omy with End-to-end Anastomosis A, B, C, & D							
Fallopian Tube/ Vagina) Hysterectomy (Corpus Uteri) A. B. C. & D Partial Gastre	ectomy with End-to-end Anastomosis A, B, C, & D							
Salpingectomy (Fallopian tube) A, B, C, & D Cystectomy F	or Carcinoma-In-Situ Urinary Bladder/ A, B, C, & D inoma Of The Bladder							
Oopherectomy (Ovary) A, B, C, & D Note: Assessment of claims and provision of benefits will be based on the Policy mentioned in this form	m.							
SECTION A : Medical Record of the Patient								
. 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 consult:	ation 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 YFS NO Day	Month Year							
II. Diabetes Mellitus YES NO Day	Month							
iii. Hyperlipidemia YES NO Day	Month Year							
iv. Others, please specify								
	Day Month Year							

SECTION B	i) ibe)			 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 			
Was biopsy done? If Yes, please attach histop YES NO If No, please provide the reason of biopsy not							
2. Was imaging done? YES NO If Yes, please provide the details & attach all in	maging reports.						
3. For Female Cancer only. a. Has the patient undergone PAP smear? YES NO If Yes, please provide date of the latest sme Day Month b. Did the patient's earlier smear show abnorr YES NO If Yes, please provide the details on the foll	nal results?	ear					
Date (DD/MM/YYYY)	owing.			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 appro Pre-Malignant Non-Invasive Carcinoma-In-Situ	priate box)			Borderline Malignancy Malignant Potential ancy			
6. Please confirm on the following. If Yes, please	provide the det	ails.					
a. Was the cancer completely localized?	YES	NO					
b. Was there invasion of tissues?	YES	NO NO					
c. Were regional lymph nodes involved?	YES	NO					
d. Was there distant metastasis?	YES	NO NO					
7. Is the diagnosis falling within any of the follow	wing condition(s))?					
a. T1N0M0 Urinary Bladder Cancer		YES	NO	If Yes, please provide the details.			
b. Papillary Carcinoma of bladder		YES	NO	(E.g. Type of Tumour, RAI staging, Breslow classification, etc.)			
c. Malignant Melanoma		YES	NO				
d. Skin Cancer		YES	NO				
e. Stage 1 Hodgkin's Disease		YES	NO				
f. Tumours manifesting as complications of A	IDS	YES	NO				
g. Stage 1 Prostate Cancer		YES	NO NO				
h. T1N0M0 Thyroid Cancer		YES	NO				
i. Chronic Lymphocytic Leukemia less then RA	Al stage 3	YES	NO				

8. What is the nature of treatm	nent?								
Treatment	Date (DD/MM/	YYYY)			Type and Details				
Surgery									
Radiotherapy									
Chemotherapy									
Others, please specify.									
Oleman attends and if and towns			lists a sthell sure suresi		(UDS) /Diamon and Diam	d a d l a.	haveter test results Bare		
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 relate	ed to the exposure o	f radioactive s	substance or radiation	?					
YES	10								
If Yes, please provide the det	tails.								
10. Is the cancer condition new	yly diagnosed or recu	rrent case?	Diagnosis Date		Final diagnosis		Treatment(s)		
New diagnosis	Recurrent d	iagnosis	(DD/MM/YYYY)						
If this is recurrent case, please	provide the following	g details in							
the table.	provide the following	5 actails							
SECTION C : Others Medica	I Information								
1. Has the patient previously suffered from this illness or any related illness or any other illnesses?									
	10	ss or any relati	tea miless or any our						
If Yes, please provide details	s as required below.		1						
Date of Consultation (DD/MM/YYYY)	lness/ Diagnosis	• •	eatment Received/ f Hospitalisation	li	nvestigation Result		of Doctor & Name of Hospital/ lical or Healthcare Facilities		
2. Was the patient referred to y	ou?								
YES	NO								
If Yes, please provide details	below and enclose	copy of the r	eferral letter (if any):						
Name & Address of Referral Doctor									
SECTION D : Attending Doctor's Declaration									
I hereby certify that:									
			examined and treated	the pati	ient for the illnesses/ injur	ies susta	ined; 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	:		Da			:			
Name	:				address of Hospital/ Clinic	:			
Professional Qualification	:		Of	nciai Sta	amp of the Doctor	:			
MMC/ Registration Number	:								