CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Other Illnesses

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

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
☐ HIV Infection due to Blood Transfusion / Organ Transplant	A, B, M & N
☐ HIV Infection due to Assault	A, B, M & N
☐ Occupationally Acquired HIV / Hepatitis B or C Infection	A, B, M & N
☐ Full Blown AIDS	A, C, M & N
☐ Aplastic Anaemia (Acute or Chronic)	A, D, M & N
☐ Myelodysplastic Syndrome or Myelofibrosis	A, D, M & N
☐ Loss of Independent Existence	A, E, M & N
☐ Loss of Speech (due to neurological disease or injury)	A, F, M & N

	Sections to be completed
☐ Facial Reconstructive Surgery	A, G, M & N
☐ Type 2 Diabetic Retinopathy	A, H, M & N
☐ Limb Amputation due to Type 2 Diabetic	A, I, M & N
☐ Complications Major Organ Transplant or Bone	A, J, M & N
☐ Marrow Transplant Pending Major Organ Transplant	A, J, M & N
☐ Small Bowel Transplant	A, K, M & N
☐ Terminal Illness	A, L, M & N

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 during the first consultation with you.

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 11601127

SECTION B

- **HIV Infection due to Blood Transfusion / Organ Transplant**
- **HIV Infection due to Assault**
- **Occupationally Acquired HIV / Hepatitis B or C Infection**

1. How did the patient contract the HIV / Hepatitis B or C infection?

i.	Intravenous drug use	☐ YES	☐ NO
ii.	Sexual activity	☐ YES	☐ NO
iii.	Physical / Sexual assault	☐ YES	☐ NO
iv.	Blood transfusion / Organ transplant	☐ YES	☐ NO
v.	Maternal-fetal transmission	☐ YES	☐ NO
vi.	Occupational exposure	☐ YES	☐ NO

If Yes for no.ii, please specify if the patient is a homosexual or sexual worker.

If Yes for no.iii, kindly submit the following documents :
a) Police report (on the incident)
b) Doctor's report (that document physical or sexual assault)

If Yes for occupational exposure, please provide the details below,

a. Actual occupation	
b. Place of work	
c. Details of the injury/incident	
d. Details of post-exposure management	

vii. Others, please explain

2. Was a HIV / Hepatitis B or C antibody test done *before* the blood transfusion / organ transplant / assault?

☐ YES ☐ NO

Was a HIV / Hepatitis B or C antibody test done *after* the blood transfusion / organ transplant / assault?

☐ YES ☐ NO

If Yes, what was the results and kindly provide copy of laboratory test results.

3. Why was the patient receiving blood transfusion / organ transplant?

☐ Part of a medical treatment ☐ Due to accident

Please provide details of the medical condition/ accident details.

4. Was the blood transfusion / organ transplant medically necessary or given part of treatment?

☐ YES ☐ NO

5. On what date and at which hospital did the blood transfusion / occupational injury incident / organ transplant take place?

Date (DD/MM/YYYY)	**Hospital / Clinic / Healthcare premises**

6. Is the hospital institution able to trace the origin of the HIV tainted blood?

☐ YES ☐ NO

If Yes, please provide details of tainted blood.

7. Was a statement from a statutory Health Authority given confirming that the infection was acquired through blood transfusion / organ transplant / occupational injury incident?

☐ YES ☐ NO

If Yes, please provide a statement from Health Authority as evidence of proof of incident.

Please attach certified true copies of all relevant reports. (E.g. HIV or Hepatitis antibody test results before and after blood transfusion, organ transplant or needle-stick injury, Statement from Health Authority on proof of incident, etc.)

SECTION C

- **Full Blown AIDS**

1. Is there a HIV antibody test or Western Blot test performed?

☐ YES ☐ NO

Please provide dates and results of all investigations done (including but not limited to HIV Ab, Western blot etc) to confirm the diagnosis of HIV/AIDS and attach copies of all relevant laboratory results.

2. At the time of diagnosis, what was the patient's CD4 cell count?

Does the patient have evidence of opportunistic infection and/or AIDS related tumours? If Yes, please provide details.

☐ YES ☐ NO

3. Please tick [✓] if the following conditions are present.

- ☐ Wasting Syndrome, please provide details of weight loss and the duration.
- ☐ Kaposi Sarcoma
- ☐ Pneumocystic Carinii Pneumonia
- ☐ Progressive Multifocal Leukoencephalopathy
- ☐ Active Tuberculosis
- ☐ Less than one-thousand (1000) lymphocytes
- ☐ Malignant Lymphoma
- ☐ Spouse and sexual partners of the above groups

Please attach certified true copies of all relevant reports (E.g. HIV (Human Immuno-deficiency Virus) antibody test, Confirmatory Western Blot test, Laboratory reports of CD4 cell count, Any Other investigation results and reports, etc.)

SECTION D ▪ Aplastic Anaemia / Chronic Aplastic Anaemia ▪ Myelodysplastic Syndrome Or Myelofibrosis

1. Please select the applicable medical condition,

☐ Aplastic anaemia ☐ Myelodysplastic syndrome or Myelofibrosis

If **aplastic anaemia** is selected, please choose the onset of the disease.

☐ Acute ☐ Chronic

2. Please state the underlying cause of the condition.

3. Was there a bone marrow biopsy to confirm the diagnosis? If Yes, please attach copy of biopsy report.

☐ YES ☐ NO

If No, please state the reason why Bone Marrow biopsy was not done.

4. At time of diagnosis, what was the haemoglobin level, red cell count, white cell count and platelet count?

i. Haemoglobin level

ii. Red cell count

iii. White cell count

iv Platelet count

5. Please provide date of last consultation and the Full Blood Count level on last consultation.

Date of Last Consultation (DD/MM/YYYY)	Full Blood Count Level

6. Were the following treatment given?

Treatment		If Yes, please provide details
Regular blood product transfusion	☐ YES ☐ NO	If Yes, please state frequency of transfusion and blood product transfused.
Marrow stimulating agents	☐ YES ☐ NO	If Yes, please state the medications and dosage.
Immunosuuppressive agents	☐ YES ☐ NO	If Yes, please state the medications and dosage.
Bone marrow transplantation	☐ YES ☐ NO	If Yes, please provide date of transplant and hospital/doctor involved.

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, etc.)

SECTION E ▪ Loss of Independent Existence

1. Please describe the latest physical or mental impairment of the patient as of the last consultation with you.

Date of Last Consultation (DD/MM/YYYY)	Physical or Mental Impairment

2. Details of treatment rendered.

3. Was there any surgery performed?

☐ YES ☐ NO

If Yes, please provide details of surgical procedure and date performed.

Date of Surgery (DD/MM/YYYY)	Details of Surgical Procedure

4. If the patient is not bedridden, please indicate the activities of daily living (ADL) that the patient is NOT able to perform with or without the use of mechanical equipment, special devices or other aids and adaptations. Please tick [✓] the appropriate ADL.

☐ Transfer – Getting in and out of a chair without requiring physical assistance

☐ Mobility – Abillity to move from room to room without requiring physical assistance

☐ Continence – Ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene

☐ Dressing - Putting on and taking off all necessary items of clothing without requiring assistance from another person

☐ Bathing/Washing – Ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other means

☐ Eating - All tasks of getting food into the body once it has been prepared

5. How long has such inability been documented (in months)?

☐ months

6. Is such inability expected to be permanent?

☐ YES ☐ NO

7. Is there any current medical treatment/surgery which could improve the patient's condition?

☐ YES ☐ NO

If Yes, please provide details.

8. What is the progress of recovery, if any?

9. What is the prognosis?

☐ Retrogressed ☐ Static ☐ Improving ☐ Recovered

Please attach copies of all the relevant reports of tests available (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, etc.)

SECTION F ▪ Loss of Speech *(To be completed by the ENT specialist)*

1. What is the underlying cause of the patient's inability to speak?

2. Was the inability to speak related to the vocal cord?

☐ YES ☐ NO

If Yes, please provide medical evidence to confirm injury or illness to vocal cords.

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3. Is the loss of speech

i. Total ☐ YES ☐ NO

ii. Permanent ☐ YES ☐ NO

iii. Irrecoverable ☐ YES ☐ NO

iv. Psychiatric Related ☐ YES ☐ NO If Yes, please provide details

4. What was the duration of loss of speech?

i. A continuous period of 6 months ☐ YES ☐ NO

ii. A continuous period of 12 months ☐ YES ☐ NO

iii. Others, please specify

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, Medical evidence to confirm injury or illness to the vocal cords to support this disability by an Ear, Nose, Throat Specialist (ENT))

SECTION G ▪ Facial Reconstructive Surgery

1. Was the condition caused by an accident?

☐ YES ☐ NO

If Yes, please provide the following information.

i. Date of Accident (DD/MM/YYYY)

ii. Was police report lodged?

☐ YES ☐ NO If Yes, please provide a copy of the report.

iii. Was there reason to suspect that there were contributory circumstances which led to the injury (E.g. under influence of alcohol, drugs, fits and etc)?

☐ YES ☐ NO

If Yes, please state such information.

iv. Was the injury a result of a self-inflicted injury or mental illness?

☐ YES ☐ NO

If Yes, please provide details.

2. Please provide details of any facial disfigurement sustained and enclose copies of radiological/ imaging reports.

3. Was surgery performed?

☐ YES ☐ NO

If Yes, please provide the following information and enclose copy of hospitalization itemized bill.

Date of Surgery (DD/MM/YYYY)	Details of Surgical Procedure	Doctor Name & Address

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, Police Report, etc.)

SECTION H ▪ Type 2 Diabetic Retinopathy

1. Type of Diabetes and type of Retinopathy.

☐ Diabetes Mellitus Type 1 ☐ Diabetes Mellitus Type 2 Type of Retinopathy

2. Please specify which eye is affected by Diabetic Retinopathy?
Also, please attach copy(ies) of Fluorescent Fundus Angiography report or any other equivalent diagnostic tests with report.

3. Does the patient require laser treatment or vitrectomy for his/her condition?

☐ YES ☐ NO

4. Please state the type of treatment and date(s) of treatment and enclose detailed report.

Date of Treatment (DD/MM/YYYY)	Details & Type of Treatment

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT Scanning, Imaging reports, Blood and laboratory test results, Surgical reports and any relevant hospital reports, Diagnostic test results Police Report where relevant, Any clinical assessment report, etc.)

SECTION I ▪ Limb Amputation due to Type 2 Diabetic Complications

1. Please state the underlying cause for the condition. If the underlying cause is Diabetes Mellitus, please state type 1 or type II

2. Was surgery performed?

☐ YES ☐ NO

If Yes, please provide details of the surgery and copies of operation report.

Date of Surgery (DD/MM/YYYY)	Details of Surgical Procedure	Doctor Name & Address

3. Was amputation done?

☐ YES ☐ NO

If Yes, please state the site/ area of amputation.

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT Scanning, Imaging reports, Blood and laboratory test results, Surgical reports and any relevant hospital reports, Diagnostic test results Police Report where relevant, Any clinical assessment report, etc.)

SECTION J ▪ Major Organ Transplant or Bone Marrow Transplant ▪ Pending Major Organ Transplant

1. Please provide full and exact details of the diagnosis and disease leading to transplant surgery.

2. On what date did the patient become aware of the condition necessitating surgery?

☐ Day ☐ Month ☐ Year

3. Which organ is involved (E.g. kidney, lung(s), liver, heart, pancreas, small bowel or bone marrow)?

4. What is the condition/ illness leading to the necessity of organ transplant?

5. For human bone marrow, is it using hematopoietic stem cells preceded by total bone marrow ablation?

☐ YES ☐ NO

6. Has the patient undergone the transplant surgery as a recipient?

☐ YES ☐ NO

If Yes, please provide details of transplant surgery performed.

Date of Surgery (DD/MM/YYYY)	Type of Transplant	Doctor & Hospital Name

If No, please state if the patient is on an official Malaysia waiting list as a recipient for a transplant? Please submit the official confirmation document:

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7. What is the prognosis?

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgical Report for Major Organ Transplantation, etc.)

SECTION K ▪ Small Bowel Transplant

1. For small bowel transplant, please state the length of the small bowel transplanted.

☐ Meter

2. Has the patient undergone the transplant surgery as a recipient?

☐ YES ☐ NO

If Yes, please provide details of transplant surgery performed.

Date of Surgery (DD/MM/YYYY)	Type of Transplant	Doctor & Hospital Name

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgical Report for Major Organ Transplantation, etc.)

SECTION L ▪ Terminal Illness

1. Please give details of symptoms and treatment during the last consultation.

Date of Last Consultation (DD/MM/YYYY)	Physical or Mental Impairment

2. Is the patient's condition incurable and beyond any hope of recovery?

☐ YES ☐ NO

3. In your opinion, is the patient's illness/condition terminal?

☐ YES ☐ NO

4. In your opinion, what is the estimated life expectancy of the patient?

5. What treatment is the patient currently receiving?

6. How effective is the treatment given in alleviating the symptoms and controlling the condition?

7. Has active therapy now been rejected in favour of palliative care?

☐ YES ☐ NO

If Yes, please elaborate.

8. I I·ă űKŜ ǕI·űʎŜyű ŜǾŜ ōŜŜy̸űŜăűŜŘ ǕƻăʎűʎǾŜ ŦƻǋI Ⅼ±κ!Ⅼ5{ ƻǋ ʎă KŜκăKŜ I·ǿI·ʎűʎyƎ űKŜ ǋŜădzťű ƻŦ ădzŎK I· űŜăűK

☐ YES ☐ NO

If Yes, please elaborate.

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgical Report for Major Organ Transplantation, etc.)

SECTION M : 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 N : 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 Hospital/ Doctor :