Allianz Life Insurance Malaysia Berhad ***(198301008983)***
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT
CANCER

Policy/Policies No. _____

1. This printed form is issued on receipt of notice of illness, and is no way an admission of liability.
2. This form is to be completed by the Attending Doctor at claimant's expenses.
3. The original or certified true copy of the related investigation reports must be attached to substantiate the claim. *(including but not limited to Histopathology Examination Report, Biopsy Report, Computed Tomography Scan, Magnetic Resonance Imaging, Pap Smear, etc.)*

This claim is being filed for : *(Please tick [√] in the appropriate box)*

- ☐ Cancer
- ☐ Carcinoma in situ
- ☐ Early Cancer (Prostate, Thyroid, Bladder, Chronic Lymphocytic Leukemia, Melanoma)
- ☐ Cerebral Metastasis
- ☐ Radical Surgery for Carcinoma in situ/Early Cancer:
  - ☐ Radical Mastectomy
  - ☐ Radical Prostatectomy
  - ☐ Radical Thyroidectomy
  - ☐ Radical Hysterectomy
  - ☐ Oophorectomy
  - ☐ Salpingectomy
  - ☐ Partial Colectomy with end to end anastomosis
  - ☐ Partial Gastrectomy with end to end anastomosis

PERSONAL PARTICULAR OF PATIENT

Name : _____ Age/Sex : _____

NRIC/Passport : _____ Occupation : _____

1. Please give details of patient's past medical history, lifestyle *(e.g. smoker, drinker, etc.)*, comorbidities and any information that are deemed necessary.

   _____

   _____

2. Are you aware of any members of patient's close family who have suffered from this or any similar condition? If yes, please give details.

   _____

   _____

GENERAL INFORMATION

1. Are you the patient's Usual Medical Attendant? If so, since when? ☐☐☐☐☐☐ (DD/MM/YY)
2. If no, please give name and address of his/her Usual Medical Attendant if it is known to you.

   _____

   _____

3. Date you first saw the patient for this condition. ☐☐☐☐☐☐ (DD/MM/YY)
4. Was the patient being referred to you? If yes, please indicate name and address of the referral doctor.

   _____

   _____

5. What were the symptoms the patient complaint of when he/she first saw you?

_____

6. According to the patient, how long had he/she been experiencing these symptoms prior to consulting you?

_____

7. In your professional opinion, how long would it take for the patient condition to develop?

_____

8. What was your final diagnosis established?

_____

_____

(a) On what date was the diagnosis established? ☐☐☐☐☐☐ (DD/MM/YY)

(b) On what date was the patient first made aware of it? ☐☐☐☐☐☐ (DD/MM/YY)

9. Was the condition diagnosed related directly, indirectly, partly or wholly to:

(a) Congenital defect or disease YES / NO

(b) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection YES / NO

(c) Alcohol or drug abuse YES / NO

10. Was the patient suffering from any of the following comorbidities? *(Please tick [√] in the appropriate box.)*

☐ Hypertension ☐ Diabetes Mellitus ☐ Hyperlipidaemia

☐ Others, kindly specify : _____

11. Kindly provide details for Q10.

Date	Diagnosis	Treatment	Doctor/Hospital

DETAILS OF ILLNESS

1. Please give details of the diagnosis:

   (a) Type of the tumour _____

   (b) Site of the tumour _____

   (c) Staging and classification of the tumour _____
   (e.g. TNM, RAI, etc.)

2. Was biopsy done? If yes, kindly provide the results. ☐☐☐☐☐☐ (DD/MM/YY)

   _____

   _____

3. If no, kindly provide the reason(s) why biopsy was not done.

   _____

4. Was there any other investigation test or imaging done to confirm the diagnosis? If yes, kindly provide details.

Date	Type of Investigation	Investigation Result

5. Kindly confirm on the following:

   (a) Was there an uncontrolled growth of malignant cells? YES / NO
   (b) Was the cancer completely localized? YES / NO
   (c) Was there any invasion of tissue? YES / NO
   (d) Were regional lymph nodes involved? YES / NO
   (e) Was there any distant metastasis? YES / NO

6. Was the cancer histologically classified as: *(Please tick [√] in the appropriate box.)*

   ☐ Carcinoma in situ ☐ Non-invasive ☐ Having low malignant potential
   ☐ Pre-malignant ☐ Having borderline malignancy ☐ **None of the above**

7. Please tick [√] if the diagnosis falls under any of the following.

   ☐ Tumours of the prostate classified as T1N0M0
   ☐ Tumours of the thyroid classified as T1N0M0
   ☐ Tumours of the urinary bladder classified as T1N0M0
   ☐ Papillary carcinoma of the bladder
   ☐ Chronic Lymphocytic Leukaemia less than RAI Stage 3
   ☐ Stage 1 Hodgkin's disease
   ☐ Skin cancer (other than malignant melanoma)
   ☐ Cervical Intraepithelial Neoplasia
   ☐ Non-melanoma Carcinoma-in-situ
   ☐ Carcinoma-in-situ of the biliary system
   ☐ **None of the above**

   If yes, kindly provide the details. *(e.g. type of tumour, staging, classification, etc.)*

   _____

8. Was there any surgical procedure performed? If yes, kindly provide details. | | | | | | | (DD/MM/YY)

_____

_____

9. If no, kindly provide details of the treatment.

_____

_____

***For Cerebral Metastasis only (Question 10)**

10. Additional information for **Cerebral Metastasis**:
    (a) Was there evidence of increasing tumor size? YES / NO
    (b) Was there worsening neurological dysfunction? YES / NO

OTHER INFORMATION

1. Has the patient previously received treatment for the above condition elsewhere? If yes, kindly provide details such as date, diagnosis, treatment, treating doctor and hospital.

_____

_____

2. Please give names and addresses of all other Medical Practitioner whom, to your knowledge, had attended to the patient for this condition.

_____

_____

3. Please state from your records the details of all illnesses, accidents, surgical operations or diseases from which the patient had suffered or had been treated. *(Please use additional sheet, if necessary.)*

Date	Diagnosis	Treatment	Doctor/Hospital

4. Please give any other information which you feel would be helpful in the assessment of your patient's claim.

_____

_____

I hereby certify that I have examined the above patient and that the injury/sickness stated above represent my medical opinion of the patient's condition.

Name of Doctor : _____

_____ Qualification / Specialty : _____

Signature
Date :

_____ _____

Doctor's Stamp Hospital/Clinic Stamp