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# CRITICAL ILLNESS CLAIM FORM

## ATTENDING PHYSICIAN'S STATEMENT

Agency/Agent's Code _____
Policy No. _____ Service No. _____ (Office use only)

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 For Critical Illness claim, the original or certified true copy of the investigation or histology reports must be attached to substantiate the claim.

### DEFINITION

Coma is defined as :

A stage of unconsciousness with no reaction to external stimuli or internal needs,persisting continously with the use of life support systems for a period of at least 96 hours, requiring the use of life support systems and resulting in a neurological deficit, lasting more than thirty (30) days. Confirmation by a neurologist must be present.

### PERSONAL PARTICULAR

1 Name : _____ I.C. No : _____

2 Occupation: _____ Age/Sex : _____

3 Please give details of your patient's smoking habits, both past and present.

_____

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

_____

### ILLNESS

5 Date you first saw the patient for this condition. ☐☐☐☐☐☐ (DD/MM/YY)

6 Was the patient referred to your clinic by any other doctor ? If yes, please indicate name and address of the referral doctor.

_____

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

_____

8 According to the patient, how long had he/she been experiencing these symptom prior to consulting you?

_____

9 In your professional opinion, how long would it take for the patient condition to develop ? Kindly advise reason if answer in Q( 8 ) and Q( 9 ) is different.

_____

_____

10 What was your diagnosis ? Kindly advise date of diagnosis.
i Diagnosis : _____ Date : ☐☐☐☐☐☐ (DD/MM/YY)

_____

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ii Please confirm the coma as described above.

iii Please confirm that there was a continuous need for the use of life support systems, please give dateils.

iv Was the patient reacted to external stimuli or internal needs ? Please give deatils.

v Has the coma lasted for 96 hours? Please give details.

vi Has the coma resulting in a neurological deficit, lasting more than thirty (30) days.

☐ Yes ☐ No

vi Please describe the exact details of your patient's conditon, including details of underlying cause.

11 Have the patient previously received treatment for the above condition ? ☐ Yes ☐ No
If yes, please give details of treatment inclusive of date, name and address of the doctor.

| Date | Doctor's name and address | Treatment |
|---|---|---|
| | | |
| | | |
| | | |

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

**GENERAL INFORMATION**

13 Are you the patient's Usual Medical Attendant? If so, since when?

14 If no, please give name and address of his/her Usual Medical Attendant if known to you.

15 Please state from your records the details of all illnesses, accidents, surgical operations or disease from which the deceased had suffered or had been treated at your clinic. (Please use additional sheet, if necessary.

| Date of Consultation | Diagnosis | Treatment |
|---|---|---|
| | | |
| | | |

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.

Signature
Date :

Name of Doctor :
Qualification :

Hospital/Clinic Stamp