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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

Multiple Sclerosis is defined as :

Unequivocal diagnosis by a Consultant Neurologist confirming more than one episode of well defined neurological deficit, of at least six months continuous duration, with persisting signs of involvement of the optic nerves, brain stem and spinal cord together with impairment of co-ordination and motor and sensory function, with the Life Assured not necessarily confined to a wheelchair.

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 Please give the name and address of all consultants, specialists or hospitals attended by your patient for this condition

_____

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

_____

8 When did your patient first become aware of this condition

_____

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 firm diagnosis.
i Diagnosis : _____ Date : ☐☐☐☐☐☐ (DD/MM/YY)

_____

ii Name and address of the neurologist who has confirmed the diagnosis of multiple sclerosis

_____

_____

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ii Please describe the exact details of your patient's condition.

iii Has your patient suffered any previous episodes of this condition or any conditions leading to it or relating to it? If so, please give details.

iv How long has your patient been experiencing these abnormalities and have they been present continuously?

v Please describe the neurological abnormalities that your patient has experienced.

vi Have any other investigatory tests or procedures been performed? If so, please give details.

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 your patient had suffered or had been treated at your clinic. (Please use additional sheet, if necessary.

Date of Consultation	Diagnosis	Treatment

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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 : _____

Signature

Qualification : _____

Date :

_____

Hospital/Clinic Stamp