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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

Primary Pulmonary Arterial Hypertension is defined as :

Means primary pulmonary hypertension with substantial right bentricular enlargement established by investigations including cardiac catherterization, resulting in permanent irreversible physical impairment to the degree of at least Class 3 of the New Work Heart association Classification of cardiac impairment, and resulting in the Life Assured being unable to perform his/her usual occupation

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)

ii Please describe full details of your patient condition.

_____

_____

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iii Was there dyspnoea and fatigue ☐ Yes ☐ No

iv Was there increase left atrial pressure of at least 20 units or more? ☐ Yes ☐ No

v Was there pulmonary resistance of at least 3 units above normal? ☐ Yes ☐ No

vi Was there pulmonary artery pressure at least 40mm Hg ? ☐ Yes ☐ No

vii Was there pulmonary wedge pressure of at least 6mm Hg ? ☐ Yes ☐ No

viii Was there right ventricular end-diastolic pressured of at least 8mm Hg ? ☐ Yes ☐ No

ix Was there right ventricular hypertrophy, dilation and signs of right heart failure and decompensation ? ☐ Yes ☐ No

x Kindly advise if the patient is able to perform his/her usual occupation ☐ Yes ☐ No

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