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

ACQUIRED IMMUNO-DEFICIENCY SYNDROME (AIDS)

A) AIDS Due to Blood Transfusion

The Life Assured being infected by HIV virus or AIDS provided that:

- The infection is due to blood transfusion received in Malaysia or Singapore after The commencement of The policy
- The Life Assured is not a hemophiliac; and
- The Life Assured is not a member of any high-risk groups such as but not limited to homosexuals, intravenous drug users or sex workers.

Notification & proof of incident will be required via a statement from a statutory Health Authority that the infection is medically acquired.

B) Full Blown AIDS

The clinical manifestation of AIDS must be supported by the results of a positive HIV (Human Immuno-deficiency Virus) antibody test and a confirmatory Western Blot test. In addition, the life Insured must have a CD4 cell count of less than two hundred (200) and one (1) or more of the following criteria are met :

- Weight loss of more than ten percent of body weight over a period of six(6) months or less (wasting syndrome);
- Kaposi Sarcoma
- Pneumocystic Carinii Pneumonia;
- Progressive multifocal leukoencephalopathy
- Active Tuberculosis
- Less than one-thousand (1000) lymphocytes;
- Malignant Lymphoma

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 Is there any clinical manisfestation of AIDS? If so, please provide details.

____

11 What was your diagnosis ? Kindly advise date of diagnosis.

i Diagnosis : ________________ Date : ☐☐☐☐☐☐ (DD/MM/YY)

____

ii Date when the patient first became aware of the condition

____

iii Diagnosis was first made by :-

Name of Doctor	Name and AddressClinic/Hospital	Treatment

iv Please provide dates and results of all investigations done to confirm the diagnosis of AIDS and attach copies of all relevant laboratory reports.

Date	HIV antibody test	Western blot Test Result

12 During diagnosis, what is the patient's CD4 cell count?

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

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ii Is there any known cure for full blown AIDS? If so, please provide details.

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____

Applicable to AIDS Due to Blood Transfusion only

13 Did the assured belong to any of the following groups?

a) Homosexual or bisexual behavior group	☐ Yes	☐ No
b) Haemophiliacs	☐ Yes	☐ No
c) Intravenous drug user	☐ Yes	☐ No
d) Sexual partner of the above groups	☐ Yes	☐ No

14 Please provide details of the patient's lifestyle, personal and family medical history.

____

____

15 Kindly furnish us the below information:-

a) Reasons of a blood transfusion was given to the patient

____

b) Date the blood transfusion was given.

____

c) Was the blood that was transfused screened for antibodies to the HIV?

____

d) Name and address of the hospital where the blood transfusion was carried out

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GENERAL INFORMATION

16 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

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

____

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

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

____

20 Please state from your records the details of all illnesses, accidents, surgical operations or disease from which the patient 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