

**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

Benign brain tumour is defined as :

A non-cancerous tumour in the brain.
Cysts, granulomas, malformations in, or of, the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered.'

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.

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 (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 :

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 (DD/MM/YY)

ii Give details of the type of tumour.

iii Please give an exact description of the site of the tumour. (in or of the arteries or veins of the brain)

iv Please confirm the staging of tumour.

v Would you classify your patient's condition as our definition ? 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 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