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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

Blindness is defined as:-
The total and permanent loss of sight of both eyes.

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 ? ☐ Yes ☐ No
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 Kindly furnish us the date of the patient first become aware of the illness ?
☐☐☐☐☐☐ (DD/MM/YY)

_____

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

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ii Were there any associated systemic diseases?

iii Is there any residual vision in either eyes ? ☐ Yes ☐ No
If 'yes', please give details of the degree of vision - in numerically where possible.

iv Is there any surgery available that could re-instate vision in either or both eyes ?

v Please confirm whether blindness in both eyes will be of a permanent nature.

vi Would you classify your patient's condition as our definition ? Please give details.

12 What was the treament given to the patient ?

13 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

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

GENERAL INFORMATION

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

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

17 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