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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

LOSS OF HEARING / DEAFNESS

Total, permanent and irreversible loss of hearing in both ears as a result of disease or accident. Medical evidence in the form of an audiometry and sound-threshold tests must be provided.

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.

_____

5 Is there anything in the patient's lifestyle or personal medical history which would have increased the risk of deafness ?

_____

ILLNESS

6 Date you first saw the patient for this condition. ☐☐☐☐☐☐ (DD/MM/YY)

7 Was the patient referred to your clinic by any other doctor ? ☐ Yes ☐ No
If yes, please indicate name and address of the referral doctor.

_____

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

_____

9 According to the patient, how long had he/she been experiencing these symptom prior to consulting you?

_____

10 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.

_____

11 Kindly furnish us the date of the patient first become aware of the condition ?
☐☐☐☐☐☐ (DD/MM/YY)

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

13 Please provide details of all investigatrions and tests carried out. E.g. Audiograte, audiometric tests, sound-thereshold tests etc.

_____

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14 Is there loss of at least 80 decibels in all frequencies of hearing ? ☐ Yes ☐ No
If no, what is the actual reading. _____

15 Is there any gradual hearing in either ear? ☐ Yes ☐ No
If yes, kindly furnish us the details of the degree of hearing. _____

16 What was the treament given to the patient ?

_____

17 Is there any possibility of a surgical operation that could re-instate the hearing in either or both ears?

_____

18 If you have indicated that there is an impairment present, can you please advise whether that impairment is permanent or temporary. If the later, can you please give an indication as to how long the impairment may last.

_____

19 Prognosis of claimant's condition

_____

20 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

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

_____

GENERAL INFORMATION

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

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

_____

24 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