Allianz

# 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

Heart Valve Replacement

The actual undergoing of open chest surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities that have occurred after the date of issue or date of reinstatement of this contract.

Repair, via valvotomy, intra-arterial procedure, key-hole surgery or similar techniques are specifically excluded.

### 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 Full details of operation performed. Date : [ | | | | | ] (DD/MM/YY)

____________________

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iii Hospital and name of surgeon undertaking the procedure.

______________________________________________

iv Date of patient aware of the diagnosis    Date : [ | | | | | ] (DD/MM/YY)

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.

______________________________________________

Has patient suffered/Is patient suffering any illness stated below?

| | | | Date | Doctor's & Hospital name |
|---|---|---|---|---|
| i) Hypertension | ☐ Yes | ☐ No | ___DD___MM___YY | |
| ii) Cardiovascular Disease | ☐ Yes | ☐ No | ___DD___MM___YY | |
| iii) Diabetes | ☐ Yes | ☐ No | ___DD___MM___YY | |

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