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CRITICAL ILLNESS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

Agency/Agent's Code : _____
Policy No. : _____

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

Renal failure is defined as :

End stage renal disease (presenting as chronic irreversible failure of both kidneys to function), due to whatever cause or causes, with the Life Assured undergoing regular peritoneal dialysis or haemodialysis or having had renal transplantation.

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

_____

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

_____

8 In your professional opinion, how long would it take for the patient condition to develop ? Kindly advise reason if answer in Q(7) and Q(8) is different.

_____

9 Please confirm the diagnosis of end stage renal failure with chronic irreversible failure of both kidneys to function.

_____

10 Kindly advise us the date of dignosis. ☐☐☐☐☐☐ (DD/MM/YY)

11 Is regular renal dialysis being performed ? If so, where ?

_____

12 Has a renal transplant taken place or is it likely to be considered in the future ?

_____

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13 Has your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If so please give details.

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

15 Have the patient previously received treatment for the above condition ? ☐ Yes ☐ No
If yes, please give details of treatment inclusive of date.

GENERAL INFORMATION

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

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

18 Was the patient referred to your clinic by any other doctor ? If yes, please indicate name and address of the referral doctor.

19 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	Disease/Injury

20 Please give names and addresses of all other Physician or Medical Practitioner whom, to your knowledge, had attended to the patient for this conditon.

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

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