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

LOSS OF INDEPENDENT EXISTENCE

Confirmation by a Consultant Physician of the loss of independent existence lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology.

The Activities of Daily Living (ADL) are
a) Transfer
b) Mobility
c) Continence
d) Dressing
e) Bathing/Washing
f) Eating

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.

_____

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10 Kindly furnish us the date of the patient first become aware of the condition ?

☐☐☐☐☐☐ (DD/MM/YY)

11 What was your diagnosis ? Kindly advise date of diagnosis.

i Diagnosis : _____ Date : ☐☐☐☐☐☐ (DD/MM/YY)

12 Please grade your patient's ability to perform the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons, as follows:

☐1 Complete functional limitation in performing the ADL as described.

☐2 Substantial limitation in performing the ADL. Requires one to one assistance to perform the activity described.

☐3 Minor limitation in performing the ADL. Assistance required on an intermittent basis or with some minor part of the activity or able to perform the ADL with the use of an aid or appliance

☐4 No functional limitation. Is able to perform the ADL independently

a) Transfer and mobility – The ability to get in and out of a chair or move from one room to room without requiring any physical assistance.

☐1 ☐2 ☐3 ☐4

b) Continence – The ability to voluntarily control bowel and bladder functions as to maintain personal hygiene.

☐1 ☐2 ☐3 ☐4

c) Dressing – putting on and taking off all necessary items of clothing without requiring assistance of another person

☐1 ☐2 ☐3 ☐4

d) Bathing/Washing – The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.

☐1 ☐2 ☐3 ☐4

e) Eating - all tasks of getting food into the body once it has been prepared.

☐1 ☐2 ☐3 ☐4

13 What was the treament given to the patient ?

_____

14 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.

_____

15 Prognosis of claimant's condition

_____

16 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

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

_____

GENERAL INFORMATION

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

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

_____

20 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