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

Systemic Lupus Erythematosus (SLE) Lupus Nephritis is defined as:

Refers to a multisystem, multifactorial autoimmune disorder which affects mostly females in their childbearing years and is characterized by the development of auto-antibodies, directed against various self-antigens. In respect of this contract, SLE will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Type III to Type IV Lupus Nephritis, established by renal biopsy) Other forms, discoid lupus, and those forms with only haematological and joint involvement will be specifically excluded.

WHO Lupus Classification:

Class		Description
Class I (minimal change)	-	Negative, normal urine
Class II (Mesangial)	-	Moderate proteinuria, active sediment
Class III (Focal Segmental)	-	Proteinuria, active sediment
Class IV (Diffuse)	-	Acute nephritis with active sediment and/or nephritic syndrome
Class V (Membranous)	-	Nephrotic Syndrome or severe proteinuria

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. Please give the name and address of all consultants, specialists or hospitals attended by your patient for this condition

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

   ____
8. When did your patient first become aware of this condition

   ____

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 firm diagnosis.

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

____

ii Name and address of the specialist who has confirmed the diagnosis of SLE

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iii Is the patient's condition restricted to those forms of SLE which involve the kidneys?

a) If yes, which class/type does the patient's condition falls under?

____

b) If no, does the patient's condition falls under other forms of SLE, discoid lupus or those forms with only haematological and joint involvement?

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iv Based on Q. 10(iii) above, does the patient's condition satisfy our SLE definition stated above?

a) If yes, please explain why?

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b) If no, please explain why ?

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

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vi How long has your patient been experiencing these abnormalities and have they been present continuously?

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vii Have any other investigatory tests or procedures been performed? If so, please give details.

Please submit copies of all blood tests, urine tests and kidney biopsy results (if available).

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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

GENERAL INFORMATION

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

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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.

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15 Please state from your records the details of all illnesses, accidents, surgical operations or disease from which your patient 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