Allianz Life Insurance Malaysia Berhad (198301008983)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

CRITICAL ILLNESS CLAIM
ATTENDING PHYSICIAN'S STATEMENT
CHILD RELATED CONDITIONS

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. The original or certified true copy of the related investigation reports must be attached to substantiate the claim. *(including but not limited to Imaging Report (CT Scan, MRI, X-ray etc.), Angiocardiography Report, Echocardiogram Report, EEG Report, Laboratory Test Report etc.)*

This claim is being filed for : *(Please tick [√] in the appropriate box and complete according to the sections specified for the respective illness as below.)*

	Sections		Sections
☐ **Hospitalisation in ICU / HDU / NICU**	A, B, G	**Infectious Disease**	
☐ **Incubation**	A, B, G	☐ Zika Virus	A, B, G
☐ **Phototherapy Treatment**	A, B, G	☐ MERS	A, B, G
Congenital Condition		☐ Ebola	A, B, G
☐ Atrial Septal Defect	A, B, G	☐ SARS	A, B, G
☐ Congenital Cataract	A, B, G	☐ Influenza A – Avian influenza A (H7N9) & A (H5N1)	A, B, G
☐ Congenital Deafness	A, B, G		
☐ Coarctation of the aorta	A, B, G	☐ Nipah Virus Encephalitis	A, B, G
☐ Cerebral Palsy	A, B, G	☐ Japanese Encephalitis	A, B, G
☐ Oesophageal Atresia	A, B, G	☐ Severe Measles	A, B, D(1), G
☐ Trachea-oesophageal fistula	A, B, G	☐ Severe Hand Foot Mouth Disease	A, B, D(2), G
☐ Cleft Lip and/ or Cleft Palate	A, B, G	☐ Chikungunya Fever	A, B, D(3), G
☐ Down's Syndrome	A, B, G	☐ Typhoid Fever	A, B, D(4), G
☐ Retinopathy of Prematurity	A, B, G	☐ Rabies	A, B, D(5), G
☐ Absence of Two Limbs	A, B, G	☐ Creutzfeldt-Jakob disease	A, B, D(6), G
☐ Anal Atresia	A, B, C(1), G	☐ Malaria	A, B, D(7), G
☐ Congenital Diaphragmatic Hernia	A, B, C(2), G	☐ Severe Dengue Hemorrhagic Fever	A, B, D(8), G
☐ Infantile Hydrocephalus	A, B, C(3), G	**Child Development Disorder**	
☐ Tetralogy of Fallot	A, B, C(4), G	☐ Autism Spectrum Disorder – Level 2 Severity	A, B, E(1), G
☐ Transposition of Great Vessel	A, B, C(5), G		
☐ Truncus Arteriosis	A, B, C(6), G	☐ Severe Attention Deficit Hyperactivity Disorder (ADHD)	A, B, E(2), G
☐ Ventricular Septal Defect	A, B, C(7), G		
☐ Spina Bifida	A, B, C(8), G	☐ **Death of unborn child**	A, B, F, G

SECTION A : PERSONAL PARTICULAR OF PATIENT

Name :_____ Age/Sex :_____

NRIC/Passport :_____ Occupation :_____

1. Please give details of patient's past medical history, lifestyle *(e.g. smoker, drinker, etc.)*, comorbidities and any information that are deemed necessary.

   _____

   _____

2. Are you aware of any members of patient's close family who have suffered from this or any similar condition? If yes, please give details.

   _____

   _____

SECTION B : DETAILS OF ILLNESS

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

2. Was the patient being referred to you? If yes, please indicate name and address of the referral doctor.

_____

_____

3. What were the symptoms when you first saw the patient?

_____

_____

4. How long had the patient been experiencing these symptoms prior to consulting you?

_____

5. In your professional opinion, how long would it take for the patient condition to develop?

_____

6. Please state the final diagnosis established and provide details below.

_____

(a) On what date was the diagnosis established?	*(DD/MM/YY)*
(b) Date of birth *(if applicable)*:	*(DD/MM/YY)*
(c) Weeks of gestation at birth *(applicable to premature birth)*:	*weeks*
(d) Weight at birth *(applicable to premature birth)*:	*g*

7. Was the diagnosis confirmed by you? **YES / NO**
If no, please state the name and specialty of the doctor who confirmed the diagnosis.

_____

8. Please provide full details of the diagnosis. *(e.g. exact site, type, associated complications etc.)*

_____

_____

9. What was the underlying cause?

_____

10. Was patient hospitalized for the above condition? If yes, please provide details below.

Hospitalisation			
Admission Date *(DD/MM/YY)*		Discharge Date *(DD/MM/YY)*	
Admission Time *(am/pm)*		Discharge Time *(am/pm)*	
ICU / HDU / NICU *(if applicable)*			
From *(DD/MM/YY)*		To *(DD/MM/YY)*	
Incubation *(if applicable)*			
From *(DD/MM/YY)*		To *(DD/MM/YY)*	

(Please attach copy of itemized bill for the admission.)

a. Was the hospitalization, confinement in ICU/ HDU/ NICU and/ or incubation **medically necessary**? Please substantiate.

_____

_____

11. Kindly provide details of the investigation test or imaging done that confirms the diagnosis.

Date	Type of Investigation	Investigation Result

12. Was the condition diagnosed arising from or accelerated, directly or indirectly, wholly or partly, by any one of the following occurrences *(Please tick [√] in the appropriate box.):*

☐ Alcohol or drug abuse of the child's mother

☐ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection

☐ Suicide, attempted suicide or intentionally self-inflicted injuries while sane or insane of the child's mother

☐ Abortion or elective termination of pregnancy by the child's mother, which is not due to medical conditions

☐ Pregnancy of the child's mother conceived through artificial insemination and/ or assisted conceptions (IVF, IUI, ICI etc.), with two (2) or more unborn children (If yes, please specify: _____)

☐ Pregnancy of the child's mother with three (3) or more unborn children (If yes, please specify: _____)

☐ Experimental treatment or unlicensed test (If yes, please specify: _____)

☐ **None of the above**

13. Kindly provide details of the treatment.

_____

_____

14. Was there any surgery performed? If yes, kindly provide details.

Date	Type of Surgery	Surgeon/ Hospital

15. Could the patient be treated conservatively (other than the above surgical procedure)?
    (a) If yes, kindly provide details.

    _____

    (b) If no, kindly explain why the procedure was medically necessary.

    _____

SECTION C : ADDITIONAL DETAILS – CONGENITAL CONDITION

Please complete the question corresponding to the respective illness as specified below.

1. ***Anal Atresia***
2. ***Congenital Diaphragmatic Hernia***
3. ***Infantile Hydrocephalus***
4. ***Tetralogy of Fallot***
5. ***Transposition of Great Vessel***
6. ***Truncus Arteriosis***
7. ***Ventricular Septal Defect***
8. ***Spina Bifida***

1. Anal Atresia

(a) Does the patient have high perforated anus? **YES / NO**

(b) Is colostomy required for the condition? **YES / NO**

2. Congenital Diaphragmatic Hernia

(a) Is there presence of abdominal organs in the chest cavity at birth? **YES / NO**

(b) Is the condition associated with the complications below:

i. Pulmonary hypoplasia **YES / NO**

ii. Underdeveloped heart **YES / NO**

3. Infantile Hydrocephalus

(a) Is there enlargement of the cerebrospinal fluid (CSF) spaces resulting from obstruction of flow pathway between the secretion sites in the ventricles and absorption sites in the subarachnoid space? **YES / NO**

(b) Is the condition serious enough to warrant the placement of a shunt? **YES / NO**

4. Tetralogy of Fallot

(a) Does the patient have any of the anatomic abnormalities below:

i. Severe or total right ventricular outflow tract obstruction (pulmonary stenosis) **YES / NO**

ii. A ventricular septal defect **YES / NO**

iii. Dextroposition of the aorta with septal override **YES / NO**

iv. Right ventricular hypertrophy as confirmed by an echocardiogram **YES / NO**

5. Transposition of Great Vessel

(a) Is the condition characterized by the following:

i. Right ventricle of the heart pumps blood from the systemic veins into the aorta **YES / NO**

ii. Left ventricle pumps blood from the pulmonary veins into the pulmonary artery **YES / NO**

6. Truncus Arteriosis

(a) Is the condition characterized by a large ventricular septal defect over a large, single great vessel (truncus) arises? **YES / NO**

7. Ventricular Septal Defect

(a) Does the condition warrant surgical closure for the reversal of hemodynamic abnormalities and the prevention of heart failure, paradoxic embolization or irreversible pulmonary vascular disease? **YES / NO**

8. Spina Bifida

(a) Is the condition associated with any of the following:

i. Meningeal cyst (meningocele) **YES / NO**

ii. Cyst containing both meninges and spinal cord (meningomyelocele) **YES / NO**

iii. Cyst containing spinal cord (myelocele) **YES / NO**

SECTION D : ADDITIONAL DETAILS – INFECTIOUS DISEASE

Please complete the question corresponding to the respective illness as specified below.

1. Severe Measles	***5. Rabies***
2. Severe Hand Foot Mouth Disease	***6. Creutzfeldt-Jakob disease***
3. Chikungunya Fever	***7. Malaria***
4. Typhoid Fever	***8. Severe Dengue Hemorrhagic Fever***

1. Severe Measles

(a) Has the disease resulted in any of the conditions below:

i. Pneumonia **YES / NO**

ii. Encephalitis **YES / NO**

iii. Convulsions **YES / NO**

iv. Hepatitis **YES / NO**

2. Severe Hand Foot Mouth Disease

(a) Is the disease associated with any of the conditions below:

i. Encephalitis **YES / NO**

ii. Myocarditis **YES / NO**

iii. Neurological deficit for at least thirty (30) days after the diagnosis **YES / NO**

If yes, please specify: _____

3. Chikungunya Fever

(a) Is the disease associated with any of the conditions below:

i. Myocarditis **YES / NO**

ii. Ocular disease (uveitis, retinitis) **YES / NO**

iii. Hepatitis **YES / NO**

iv. Severe bullous lesions **YES / NO**

v. Neurologic disease *(Meningoencephalitis, Guillain-Barré syndrome, myelitis or cranial nerve palsies)* **YES / NO**

4. Typhoid Fever

(a) Is the disease associated with any of the conditions below:

i. Internal bleeding **YES / NO**

ii. Intestinal perforation **YES / NO**

iii. Severe neuropsychiatric symptoms (delirium or psychosis) **YES / NO**

5. Rabies

(a) Is the disease associated with signs and symptoms below:

i. Muscle fasciculations **YES / NO**

ii. Delirium **YES / NO**

iii. Psychosis **YES / NO**

iv. Seizures **YES / NO**

v. Aphasia **YES / NO**

6. Creutzfieldt-Jakob disease

(a) Is the disease associated with signs and symptoms below:

i. Uncontrolled muscular spasm or tremor **YES / NO**

ii. Severe progressive dementia **YES / NO**

iii. Cerebellar dysfunction **YES / NO**

iv. Athetosis **YES / NO**

7. Malaria

(a) Was the disease confirmed with light microscopy? **YES / NO**

If yes, kindly provide result: _____ parasites/mL of blood

8. Severe Dengue Haemorrhagic Fever

(a) Is there an evidence of Dengue Shock Syndrome? **YES / NO**

(b) What is the stage of Dengue Haemorrhagic Fever based on the World Health Organization case definition?

(Grade I - IV): _____

SECTION E : ADDITIONAL DETAILS – CHILD DEVELOPMENT DISORDER

Please complete the question corresponding to the respective illness as specified below.

1. Autism Spectrum Disorder – Level 2 Severity
2. Severe Attention Deficit Hyperactivity Disorder (ADHD)

1. Autism Spectrum Disorder – Level 2 Severity

(a) Does the condition comprise any of the following criteria:

- ☐ Marked deficits in verbal / nonverbal social communication skills
- ☐ Social impairments apparent even with supports in place
- ☐ Limited initiation of social interactions
- ☐ Reduced / abnormal responses to social overtures from others
- ☐ Inflexibility of behavior
- ☐ Difficulty in coping with change
- ☐ Others, please specify: _____

2. Severe Attention Deficit Hyperactivity Disorder (ADHD)

(a) How many symptoms of **Inattention** that have **persisted for ≥ six months**? _____

(b) How many symptoms of **Hyperactivity/ Impulsivity** that have **persisted for ≥ six months**? _____

(c) Are there any ADHD symptoms that are particularly severe? **YES / NO**

If yes, please specify: _____

(d) Are there any ADHD symptoms that have resulted in marked impairment in social or occupational functioning? **YES / NO**

If yes, please specify: _____

SECTION F : ADDITIONAL DETAILS – DEATH OF UNBORN CHILD

1. Did the death of unborn child occur prior to the complete delivery/ expulsion/ extraction from the mother? **YES / NO**

2. Kindly state the number of weeks of gestation when the death of the unborn child was diagnosed. _____

3. How was the death of unborn child confirmed?

_____

_____

SECTION G : OTHER INFORMATION

1. Are you the patient's Usual Medical Attendant? If so, since when? ☐☐☐☐☐☐ (DD/MM/YY)

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

_____

_____

3. Has the patient previously received treatment for the above condition elsewhere? If yes, kindly provide details such as date, diagnosis, treatment, treating doctor and hospital.

_____

_____

4. Please give names and addresses of all other Medical Practitioner whom, to your knowledge, had attended to the patient for this condition.

_____

_____

5. Please state from your records the details of all illnesses, accidents, surgical operations or diseases from which the patient had suffered or had been treated. *(Please use additional sheet, if necessary.)*

Date	Diagnosis	Treatment	Doctor/Hospital

6. 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.

Name of Doctor : _____

Qualification / Specialty : _____

_____
Signature
Date :

_____
Doctor Stamp

_____
Hospital/Clinic Stamp