**Allianz Life Insurance Malaysia Berhad (198301008983)**
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# CRITICAL ILLNESS CLAIM FORM
## ATTENDING PHYSICIAN'S STATEMENT
HEART RELATED CONDITIONS

Policy/Policies 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 Cardiac Enzyme Test Result, Electrocardiography Report, Echocardiogram Report, etc.)*

**This claim is being filed for :** *(Please tick [√] in the appropriate box and complete **ALL** sections in this form.)*
*For **Section C: Details of Illness**, please complete according to the **Group** specified for the respective illness as below.*

| | Group: | | Group: |
|---|---|---|---|
| ☐ Coronary Artery Disease | A, B, C1, D | ☐ Cardiomyopathy | A, B, C1, D |
| ☐ Angioplasty and Other Invasive Treatments | A, B, C1, D | ☐ Hypertrophic Cardiomyopathy | A, B, C1, D |
| ☐ Heart Attack | A, B, C1, D | ☐ Primary Pulmonary Arterial Hypertension | A, B, C1, D |
| ☐ Cardiac Pacemaker Insertion | A, B, C1, D | ☐ Eisenmenger's Syndrome | A, B, C1, D |
| ☐ Cardiac Defibrillator Insertion | A, B, C1, D | ☐ Heart Valve Surgery | A, B, C2, D |
| ☐ Coronary Artery Bypass Surgery | A, B, C1, D | ☐ Percutaneous Valve Replacement | A, B, C2, D |
| ☐ Minimally Invasive Direct Coronary Artery Bypass Grafting (MIDCAB) | A, B, C1, D | ☐ Percutaneous Valvuloplasty | A, B, C2, D |
| | | ☐ Surgery to Aorta | A, B, C2, D |
| ☐ Transmyocardial Laser Therapy | A, B, C1, D | ☐ Minimally Invasive Surgery to Aorta | A, B, C2, D |
| ☐ Pericardectomy | A, B, C1, D | ☐ Large Asymptomatic Aortic Aneurysm | A, B, C2, D |
| ☐ Constrictive Pericarditis with Surgery | A, B, C1, D | ☐ Infective Endocarditis | A, B, C3, D |

## 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 : GENERAL 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 it is known to you.

_____

_____

3. Date you first saw the patient for this condition. | | | | | | | (DD/MM/YY)

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

_____

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

_____

6. According to the patient, how long had he/she been experiencing these symptoms prior to consulting you?

_____

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

_____

8. What was your final diagnosis established?

_____

_____

(a) On what date was the diagnosis established? | | | | | | | (DD/MM/YY)

(b) On what date was the patient first made aware of it? | | | | | | | (DD/MM/YY)

9. Was the condition diagnosed related directly, indirectly, partly or wholly to:

(a) Congenital defect or disease YES / NO

(b) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection YES / NO

(c) Alcohol or drug abuse YES / NO

10. Was the patient suffering from any of the following comorbidities? *(Please tick [√] in the appropriate box.)*

☐ Hypertension ☐ Diabetes Mellitus ☐ Hyperlipidaemia

☐ Others, kindly specify : _____

11. Kindly provide details for Q10.

| Date | Diagnosis | Treatment | Doctor/Hospital |
|---|---|---|---|
| | | | |

## SECTION C : DETAILS OF ILLNESS

**PART C1 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.**

- ***Coronary Artery Disease***
- ***Angioplasty and Other Invasive Treatments***
- ***Heart Attack***
- ***Cardiac Pacemaker Insertion***
- ***Cardiac Defibrillator Insertion***
- ***Coronary Artery Bypass Surgery***
- ***Cardiomyopathy***
- ***Hypertrophic Cardiomyopathy***
- ***Primary Pulmonary Arterial Hypertension***
- ***Eisenmenger's Syndrome***
- ***Minimally Invasive Direct Coronary Artery Bypass Grafting***
- ***Transmyocardial Laser Therapy***
- ***Pericardectomy***
- ***Constrictive Pericarditis with Surgery***

1. Was there a history of typical chest pain? If yes, kindly provide details of the chest pain.

_____

_____

2. Was ECG performed? If yes, kindly provide details of any ECG changes. ☐☐☐☐☐☐ (DD/MM/YY)

_____

_____

3. Was Echocardiogram performed? If yes, kindly provide details. ☐☐☐☐☐☐ (DD/MM/YY)

_____

_____

4. Was cardiac enzyme measured? If yes, kindly provide the following details.

| Cardiac Enzyme | Date | Investigation Result *(Please indicate the unit of measurement.)* |
|---|---|---|
| CPK-MB | | |
| Cadiac Troponin T | | |
| Cadiac Troponin I | | |
| Others: _____ | | |

5. Was there any narrowing of the lumen of any major coronary arteries *(**NOT** inclusive of their branches)*? If yes, kindly provide the following details.

| | Percentage of Narrowing (%) |
|---|---|
| (a) Circumflex Artery | _____ |
| (b) Right Coronary Artery | _____ |
| (c) Left Anterior Descending Artery | _____ |
| (d) Left Main Stem | _____ |

6. The findings stated in Q5 was substantiated by: *(Please tick [√] in the necessary option.)*

   ☐ Coronary angiography ☐ Non-invasive diagnostic procedures, please specify: _____

7. Was there any other investigation test or imaging done to confirm the diagnosis? If yes, kindly provide details.

| Date | Type of Investigation | Investigation Result |
|---|---|---|
| | | |

8. Was there any surgical procedure performed?
   If yes, kindly provide details. *(Please tick [√] in the appropriate box.)*

   ☐ Angioplasty
   ☐ Coronary Artery Bypass Surgery
   ☐ Pericardectomy
   ☐ Transmyocardial Laser Therapy
   ☐ Minimally Invasive Direct Coronary Artery Bypass Grafting
   ☐ Atherectomy
   ☐ Cardiac Pacemaker Insertion
   ☐ Cardiac Defibrillator Insertion
   ☐ Myomectomy
   ☐ Septal Ablation
   ☐ Others, kindly specify : _____

   (a) Details of surgery performed.

| Date | Surgical Approach<br>*(e.g. open-heart, laparotomy, intra-arterial, key-hole, laser, etc.)* | Surgeon/Hospital |
|---|---|---|
| | | |

   (b) Can patient's condition be treated via other means other than the above procedure?
      i. If yes, kindly provide details.

      _____

      ii. If no, kindly explain why the procedure was medically necessary.

      _____

9. If surgical procedure was not performed, what treatment was being rendered?

   _____

***For Cardiomyopathy / Primary Pulmonary Arterial Hypertension / Eisenmenger's Syndrome only (Question 10)**

10. For **Cardiomyopathy / Primary Pulmonary Arterial Hypertension / Eisenmenger's Syndrome**, kindly provide the following details:

    (a) Please select the degree of physical impairment in accordance to New York Heart Association (NYHA) Classification of cardiac impairment: Class I / II / III / IV

    (b) Details of diagnosis (e.g. part of cardiac structure involved, exact site, type of defect, etc.)

    _____

    _____

    (c) What was the underlying cause?

    _____

**PART C2 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.**

- ***Heart Valve Surgery***
- ***Percutaneous Valve Replacement***
- ***Percutaneous Valvuloplasty***
- ***Surgery to Aorta***
- ***Minimally Invasive Surgery to Aorta***
- ***Large Asymptomatic Aortic Aneurysm***

1. Kindly provide details of the diagnosis. *(e.g. part of cardiac structure involved, exact site, type of defect, etc.)*

   _____

   _____

2. Was there investigation test or imaging done to confirm the diagnosis? If yes, kindly provide details.

| Date | Type of Investigation | Investigation Result |
|---|---|---|
| | | |

3. Details of surgery performed.

| Date | Type of Surgery | Surgical Approach *(e.g. open-heart, laparotomy, intra-arterial, key-hole, laser, etc.)* | Indication for Surgery *(e.g. to repair valvular defect, to repair aortic aneurysm)* | Surgeon/Hospital |
|---|---|---|---|---|
| | | | | |

***For Aorta Surgery only (Question 4)**

4. Additional information for **Aorta Surgery** :

   (a) Was surgery performed on the thoracic or abdominal aorta and not its branches? YES / NO

   (b) If surgery was not performed, was the aorta enlarged and greater than 55mm in diameter? YES / NO

**PART C3 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.**

- ***Infective Endocarditis***

1. Was Blood Culture done? If yes, kindly provide results. ☐☐☐☐☐☐ (DD/MM/YY)

   _____

2. Was Echocardiogram performed? If yes, kindly provide details. ☐☐☐☐☐☐ (DD/MM/YY)

   _____

   (a) Regurgitation fraction : _____ %

   (b) Heart valve stenosis : _____ %

3. Was there any other investigation test or imaging done to confirm the diagnosis? If yes, kindly provide details.

| Date | Type of Investigation | Investigation Result |
|---|---|---|
| | | |

4. Kindly provide details of the treatment.

   _____

   _____

## SECTION D : OTHER INFORMATION

1. 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.

   _____

   _____

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

   _____

   _____

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

| Date | Diagnosis | Treatment | Doctor/Hospital |
|---|---|---|---|
| | | | |

4. 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's Stamp

_____
Hospital/Clinic Stamp