



# Health Claim Form – Cancer Plan

Policy No.:

You are to disclose to us, fully and faithfully all the facts which you know or ought to know, otherwise the claim submitted hereunder may be declined.

We are committed to protect the personal data submitted by and collected from you. For further details, please refer to our "Data Privacy Notice published in our website.

### Instructions

To speed up the claim process, please (1) Complete this form, (2) Attach relevant supporting documents i.e. Completed medical report by treating doctor, Certified copy of histopathology report(s) & Copy of final bill. You may attach other diagnostic reports whenever available.

A. DETAILS OF INSURED		
Name of Insured /Policyholder :		
NRIC / Passport No :	Contact No :	
Policy No:	Email :	
B. INFORMATION ON CANCER/TUMOUR RELATED DISEASE		
1. Date you were first diagnosed with Cancer : _____ dd _____ mm _____ yy		
Details of doctor first diagnosed the Cancer		
Name:	Address :	
Phone No :		
2. Describe the symptoms:		
3. When did you start experiencing the symptoms? Since _____ dd _____ mm _____ yy		
4. Do you have any past history of illness or conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please fill the details of previous hospital/clinic/doctor/specialist that have treated you for this illness or other condition/injury for the past 5 years (please use additional sheets if necessary):		
Name of hospital/clinic/doctor/specialist	Address	Phone No
5. Were you referred by any doctor prior to your first visit to the doctor stated in Question 1? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please state the name, address and phone no:		
Name and address of hospital	Date of Admission	Date of discharge
6. Have you been told to have symptoms of cancer or have any history of cancer before this event? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please state the type of cancer or symptoms.		
Name of cancer / symptom	Duration	

**C. DETAILS OF OTHER INSURER**

Name of company	Policy No	Amount of benefit

**D. INSURED'S BANK DETAILS**

**\*Payment advice will be sent to your e mail. Please check if your e mail address is given in Section A**

Name (as per bank acc.):		
Name of Bank :	Bank Account No.:	Bank SWIFT Code: (For foreign account only)

**E. CLAIMANT'S DECLARATION**

I hereby declare that the above statements and facts are true. I hereby authorize any physician, clinic, hospital, insurance company or any organization, institutions or person to give you full particulars about my/the patient's health policy details, medical history and billing information. I further consent to the disclosure of all such medical information and records by you to any insurers, re-insurers, solicitors, my employer, agents/brokers and other third parties in connection with my insurance claims. A duplicate of this authorization shall be as effective and valid as the original.

Signature of Insured Person / Claimant :

Name:

Date:

**F. MEDICAL REPORT ( To be completed by the patient's treating physician or surgeon )**

Name of patient :	Age :	
NRIC/Passport/Birth Certificate No :	Name of hospital :	
1. Are you patient's regular medical attendant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, for how long _____ & date you were first consulted. _____ dd _____ mm _____ yy		
2. Was this patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please provide doctor's name, address and a copy of the referral letter.		
3. First symptoms presented :		
i. Duration of first symptom : _____ dd _____ mm _____ yy		
ii. Was biopsy done for patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide date and result.		
Date	Biopsy result	Other diagnostic/investigation test result
____ dd ____ mm ____yy		
____ dd ____ mm ____yy		
____ dd ____ mm ____yy		
If No, please provide the reason biopsy not performed:		
iii. Final Diagnosis:		
iv. Diagnosis was first made by (name of doctor) :		
v. Date when patient first became aware of this diagnosis : _____ dd _____ mm _____ yy		
4. a. What is the Surgical-Pathological cancer staging for this patient?		
b. What was the cancer staging system used?		
5. Did the patient suffer from any tumour? Yes / No		
a. What is tumour grading?		
b. Site and organ involved:		
6. Was the tumour classified as:		
i. Pre-malignant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ii. Non-invasive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iii. Carcinoma-In-Situ	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iv. Having Borderline Malignancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
v. Having Malignant Potential	<input type="checkbox"/> Yes	<input type="checkbox"/> No
vi. Malignancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Please confirm the following:		
i. Was there any present of uncontrolled growth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ii. Was there any spread of malignant cells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iii. Was there invasion of tissues?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iv. Was the cancer completely localized?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
v. Were regional lymph nodes involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. Was there any distant metastasis?  Yes  No  
 What are the body parts involved?

9. If the diagnosis is Leukaemia, is it Chronic Lymphatic Leukaemia?  Yes  No  
 If Yes, please confirm the Rai stage.  
  
 If No, please provide the type of leukaemia:

10. If the diagnosis is skin cancer, is it malignant melanoma?  Yes  No  
 If Yes, please give full details of size, thickness (Breslow classification) and/or depth of invasion (Clark level) :

11. Did the patient suffer from brain tumour?  Yes  No. If yes, please answer below:

Site of brain involved	In pituitary gland	In spinal cord
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

12. Has the patient **previously** suffered from cancer or any related illness including pre-cancerous conditions?  Yes  No  
 If Yes, please give dates of consultation and the resulting diagnosis (please use additional sheets if necessary):

13. Is there anything in the patient's personal medical history and family history which would have increased the risk of cancer?  
 Yes  No. If Yes, please advise the details.

14. Other medical conditions on underlying disease present?

Medical condition	Since
	____ dd ____ mm ____ yy
	____ dd ____ mm ____ yy
	____ dd ____ mm ____ yy

15. Is the cancer related to AIDS/HIV?  Yes  No

16. Did the patient consult other doctors for this illness/symptom before coming to see you?  Yes  No  
 If Yes, please state the details below (please use additional sheets if necessary):

Name and address of hospital/clinic	Date of Admission/Date of visit	Date of discharge

I hereby certify that the answers above are full, complete and true.  
 Date: \_\_\_\_\_ Signature, name and address of physician: \_\_\_\_\_