CRITICAL ILLNESS - CANCER CLAIM (BY DOCTOR)

Important Note :
Your patient is insured with us against the happening of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.
(For any medical report fee incurred in completing this form, it will be borne by the claimant)

Policy No

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Please attach the certified true copy of all the relevant tests available.

- ☐ HPE / Biopsy Report
- ☐ Bone Marrow Aspiration
- ☐ Surgical Report
- ☐ CT Scan / MRI / Radiological
- ☐ Blood & Laboratory Results
- ☐ Others

1. Patient's details

Full Name

NRIC / OLD IC / Passport No

Occupation & exact duties

2. Medical Record

Are you the patient's regular doctor? ☐ YES ☐ NO — If YES, since when? DD MM YY

Date the patient **FIRST** consulted you for Cancer
DD MM YY

Please state the symptom presented during the FIRST consultation

Symptoms	Date symptom FIRST presented? (dd/mm/yy)

Please describe FULL and EXACT diagnosis.
_____
_____

Date when CANCER was FIRST diagnosed
DD MM YY

Diagnosis was FIRST made by (Name of Doctor & Hospital)
_____
_____

Date when patient FIRST became aware of the illness
DD MM YY

Which of the following factors are present? Please provide the date of onset

Factors	YES	NO	Date of onset (dd/mm/yy)
Hypertension			
Diabetes Mellitus			
Hyperlipidemia			
Others, please specify :			

What is the source of information :

- ☐ Patient
- ☐ Referring doctor. Name of doctor & hospital / clinic : _____
- ☐ Others, please specify : _____

What is the staging of the tumour? Please provide full details using appropriate staging classification (eg : TNM, FIGO, Ann Arbor, Duke's etc) _____	Is it classified? ☐ Borderline malignancy ☐ Having low malignant potential ☐ Having high malignant potential ☐ Pre-malignant ☐ Carcinoma-in-situ ☐ Non-invasive ☐ Invasive
The disease was : You may tick (√) more than one.	☐ Invasive to adjacent tissue ☐ Involved regional lymph nodes ☐ Distant metastatic. If so, please give details ☐ Completely localized _____
Type of investigations / test done to confirm the diagnosis.	☐ Biopsy / Histopathology ☐ Bone marrow aspirations / Trephine ☐ Others, please specify : _____ ☐ Tumour marker

What is the nature of treatment?

Treatment	Date (dd/mm/yyyy)	Type and details
Surgery		
Radiotherapy		
Chemotherapy		
Others, please specify		

Please provide the full address of any hospital to which patient has been referred together with the names of the consultant attended.

Hospital	Address	Name of Consultant	Date of Consultation

Is the Cancer associated with HIV or AIDS? ☐ YES ☐ NO	If YES, please state the date the HIV was FIRST diagnosed ☐☐ DD ☐☐ MM ☐☐ YY
Please provide us with any other information that will enable the Company to assess the claim.	_____ _____ _____

3. Declaration & Authorization

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declaration of this claim form.

Name :

Address :

Date :

Signature and Official Stamp