



# 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.

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

HPE / Biopsy Report  
Bone Marrow Aspiration  
Surgical Report

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

CT Scan / MRI / Radiological  
Blood & Laboratory Results  
Others

## 1. Patient's details

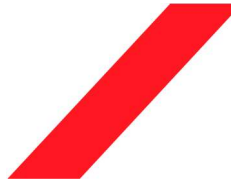
Full Name

NRIC / OLD IC / Passport No

Occupation & exact duties

## 2. Medical Record

Are you the patient's regular doctor?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, since when? <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DD</td> <td>MM</td> <td>YY</td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DD	MM	YY								
<input type="text"/>	<input type="text"/>	<input type="text"/>														
DD	MM	YY														
Date the patient <b>FIRST</b> consulted you for Cancer <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DD</td> <td>MM</td> <td>YY</td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DD	MM	YY	Please state the symptom presented during the FIRST consultation <table border="1"> <thead> <tr> <th>Symptoms</th> <th>Date symptom FIRST presented? (dd/mm/yy)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Symptoms	Date symptom FIRST presented? (dd/mm/yy)						
<input type="text"/>	<input type="text"/>	<input type="text"/>														
DD	MM	YY														
Symptoms	Date symptom FIRST presented? (dd/mm/yy)															
Please describe FULL and EXACT diagnosis. <input type="text"/> <input type="text"/>	Date when CANCER was FIRST diagnosed <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DD</td> <td>MM</td> <td>YY</td> </tr> </table>		<input type="text"/>	<input type="text"/>	<input type="text"/>	DD	MM	YY								
<input type="text"/>	<input type="text"/>	<input type="text"/>														
DD	MM	YY														
Diagnosis was FIRST made by (Name of Doctor & Hospital) <input type="text"/> <input type="text"/>	Date when patient FIRST became aware of the illness <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DD</td> <td>MM</td> <td>YY</td> </tr> </table>		<input type="text"/>	<input type="text"/>	<input type="text"/>	DD	MM	YY								
<input type="text"/>	<input type="text"/>	<input type="text"/>														
DD	MM	YY														
Which of the following factors are present? Please provide the date of onset																
<b>Factors</b>	<b>YES</b>	<b>NO</b>	<b>Date of onset (dd/mm/yy)</b>													
Hypertension																
Diabetes Mellitus																
Hyperlipidemia																
Others, please specify :																
What is the source of information :																
<input type="checkbox"/>	Patient															
<input type="checkbox"/>	Referring doctor. Name of doctor & hospital / clinic : _____															
<input type="checkbox"/>	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? <input type="checkbox"/> Borderline malignancy <input type="checkbox"/> Having low malignant potential <input type="checkbox"/> Having high malignant potential <input type="checkbox"/> Pre-malignant <input type="checkbox"/> Carcinoma-in-situ <input type="checkbox"/> Non-invasive <input type="checkbox"/> Invasive																	
The disease was : You may tick (v) more than one.		<input type="checkbox"/> Invasive to adjacent tissue <input type="checkbox"/> Involved regional lymph nodes <input type="checkbox"/> Distant metastatic. If so, please give details <input type="checkbox"/> Completely localized																	
Type of investigations / test done to confirm the diagnosis.		<input type="checkbox"/> Biopsy / Histopathology <input type="checkbox"/> Bone marrow aspirations / Trepine <input type="checkbox"/> Others, please specify : _____ <input type="checkbox"/> Tumour marker																	
What is the nature of treatment?																			
<table border="1"> <thead> <tr> <th>Treatment</th> <th>Date (dd/mm/yyyy)</th> <th>Type and details</th> </tr> </thead> <tbody> <tr> <td>Surgery</td> <td></td> <td></td> </tr> <tr> <td>Radiotherapy</td> <td></td> <td></td> </tr> <tr> <td>Chemotherapy</td> <td></td> <td></td> </tr> <tr> <td>Others, please specify</td> <td></td> <td></td> </tr> </tbody> </table>				Treatment	Date (dd/mm/yyyy)	Type and details	Surgery			Radiotherapy			Chemotherapy			Others, please specify			
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.																			
<table border="1"> <thead> <tr> <th>Hospital</th> <th>Address</th> <th>Name of Consultant</th> <th>Date of Consultation</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				Hospital	Address	Name of Consultant	Date of Consultation												
Hospital	Address	Name of Consultant	Date of Consultation																
Is the Cancer associated with HIV or AIDS? <input type="checkbox"/> YES <input type="checkbox"/> NO		If YES, please state the date the HIV was FIRST diagnosed <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 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.

Signature and Official Stamp

Name :

Address :

Date :