

CRITICAL ILLNESS – OTHER ILLNESSES (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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1. Patient's details

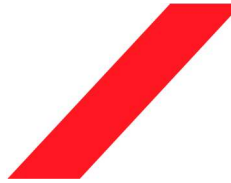
Full Name

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? <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY																				
Date the patient FIRST consulted you <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> </tbody> </table>		Symptoms	Date symptom FIRST presented? (dd/mm/yy)																		
Symptoms	Date symptom FIRST presented? (dd/mm/yy)																					
Please describe FULL and EXACT diagnosis. _____ _____	Date when the illness was FIRST diagnosed <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY																					
Diagnosis was FIRST made by (Name of Doctor & Hospital) _____ _____	Date when patient FIRST became aware of the illness <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																						
<table border="1"> <thead> <tr> <th>Factors</th> <th>YES</th> <th>NO</th> <th>Date of onset (dd/mm/yy)</th> </tr> </thead> <tbody> <tr> <td>Hypertension</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Diabetes Mellitus</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hyperlipidemia</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Others, please specify :</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Factors	YES	NO	Date of onset (dd/mm/yy)	Hypertension				Diabetes Mellitus				Hyperlipidemia				Others, please specify :					
Factors	YES	NO	Date of onset (dd/mm/yy)																			
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 underlying cause of the illness as per diagnosis above? _____ _____	
When was the underlying cause FIRST diagnosed? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY	Name of treating doctor and clinic _____ _____
Type of investigations / test done to confirm the diagnosis.	_____ _____
Please give details of completed, planned or current treatment for the illness stated above. _____ _____	What is the current condition of the Patient and what is the prognosis? _____ _____
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 :