

**CRITICAL ILLNESS CLAIM  
- ATTENDING PHYSICIAN'S STATEMENT  
KIDNEY, LIVER, LUNG RELATED ILLNESSES  
(This form to be completed by patient's attending  
doctor/specialist at patient own expense)**

Claim was filed for following illness: (Please tick [✓] for appropriate box)

- |  |  |
|--|--|
| <input type="checkbox"/> End Stage Kidney Failure                                      | <input type="checkbox"/> End Stage Liver Failure   |
| <input type="checkbox"/> Medullar Cystic Disease                                       | <input type="checkbox"/> Fulminant Viral Hepatitis |
| <input type="checkbox"/> Systemic Lupus Erythematosus with Severe Kidney Complications | <input type="checkbox"/> Chronic Lung Disease      |

**Patient's Personal Details**

Policy No.	1)
	2)
	3)
	4)
Name of Patient	
New IC/Old IC/Passport No/Birth Cert	
Date of Birth	

**A PATIENT'S MEDICAL RECORD  
(THIS SECTION IS COMPULSORY TO FILL UP FOR ALL CRITICAL ILLNESSES)**

1. Are you the patient's regular/family doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
If yes, when did the records extend?	Date: ..... / ..... / ..... (DD)        (MM)        (YYYY)																
2. Date when patient first consulted you for the illness.	Date: ..... / ..... / ..... (DD)        (MM)        (YYYY)																
3. The presenting symptoms during first consultation with you and how long did the symptoms lasting.																	
<table border="1"> <thead> <tr> <th>Sign &amp; Symptoms</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>		Sign & Symptoms	Duration														
Sign & Symptoms	Duration																
Where is the source of this information?																	
<input type="checkbox"/> Patient <input type="checkbox"/> Referring Doctor (Name of doctor and hospital/clinic) ..... <input type="checkbox"/> Others, please specify: .....																	
4. Please describe the full and exact diagnosis with investigation/test taken and treatment given.																	
<table border="1"> <thead> <tr> <th>Date (dd/mm/yyyy)</th> <th>Diagnosis</th> <th>Type of investigation/test</th> <th>Treatment</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>		Date (dd/mm/yyyy)	Diagnosis	Type of investigation/test	Treatment												
Date (dd/mm/yyyy)	Diagnosis	Type of investigation/test	Treatment														
5. Date when the patient was informed of the diagnosis.	Date: ..... / ..... / ..... (DD)        (MM)        (YYYY)																



6. Has the patient ever suffered from or diagnosed to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischemic attack, neurological disorder, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?

Yes  No

If "Yes", please provide following details:

Date of diagnosis	Illnesses	Medication/Treatment	Name of Doctor	Name and address of clinic/hospital

7. Please provide us with other information that enable the Company to assess this claim.

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.....

## B (This section is only applicable for SPECIFIC CRITICAL ILLNESSES only)

I. Applicable for - End Stage Kidney Failure, or  
 - Medullary Cystic Disease, or  
 - Systemic Lupus Erythematosus with Severe Kidney Complications

1. (a) For **CHRONIC KIDNEY FAILURE**, please confirm what is the underlying cause of illness? Please tick the relevant and provide date of onset.

Lupus Nephritis

Date: ..... / ..... / .....  
 (DD) (MM) (YYYY)

Medullary Cystic Disease

Date: ..... / ..... / .....  
 (DD) (MM) (YYYY)

Diabetes Mellitus

Date: ..... / ..... / .....  
 (DD) (MM) (YYYY)

Inherited/Hereditary/Congenital

Date: ..... / ..... / .....  
 (DD) (MM) (YYYY)

Others, please specify: .....

Date: ..... / ..... / .....  
 (DD) (MM) (YYYY)

(b) What is the stage of the renal failure?

Date of renal test done (dd/mm/yyyy)	eGFR reading	Serum creatinine	Urine FEME	Others

(c) Any renal biopsy done?  Yes  No

(d) Please confirm whether patient's condition as below.

i. End stage renal failure?  Yes  No

ii. Renal failure irreversible?  Yes  No

iii. Renal failure is acute or chronic?  Yes  No

iv. Renal failure involve both kidneys?  Yes  No

(e) Is regular hemodialysis or peritoneal dialysis being performed?  Yes  No

If YES, please state the date of dialysis FIRST started.

Date: ..... / ..... / .....  
 (DD) (MM) (YYYY)

(f) Has renal transplant taken place or likely to be considered in the future?  Yes  No

If YES, please state the date of transplantation

Date: ..... / ..... / .....  
 (DD) (MM) (YYYY)

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. renal dialysis report, renal transplantation report, renal function test (eGFR, bilirubin, albumin, creatinine ratio), urine test, ultrasound/radiological report

2. (a) For **MEDULLAR CYSTIC DISEASE**, please state the clinical manifestation

- Anaemia  Renal loss of sodium  
 Polyuria  Others, please specify: .....

(b) Any renal biopsy done?  Yes  No

(c) Has renal failure progress to chronic?  Yes  No

(d) Please state renal function, Urine FEME, imaging of kidney and other relevant test results

.....  
.....

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. urine test, renal function test (eGFR, bilirubin, albumin, creatinine ratio, electrolytes), ultrasound/radiological report*

3. (a) For **SYSTEMIC LUPUS ERYTHEMATOSUS**, please state the clinical manifestation.

- Blood  Lungs  
 Skin  Kidneys  
 Joint  Others, please specify: .....

(b) Please confirm the illness with WHO Lupus Classification as below:

- Class I (minimal change) - Negative, normal urine  
 Class II (Mesangial) - Moderate proteinuria, active sediment  
 Class III (Focal Segmental) - Proteinuria, active sediment  
 Class IV (Diffuse) - Acute nephritis with active sediment and/or nephritic syndrome  
 Class V (Membranous) - Nephrotic Syndrome or severe proteinuria

(c) What is the stage of the renal failure?

Date of renal test done (dd/mm/yyyy)	eGFR reading	Serum creatinine	Urine FEME	Others

(d) Any renal biopsy done?  Yes  No

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. renal biopsy, blood and lab test result (anti-DNA antibodies), ultrasound/radiological report, renal dialysis report, renal function test with electrolytes*

## II. Applicable for - End Stage Liver Failure, or - Fulminant Viral Hepatitis

1. (a) For **END STAGE LIVER FAILURE OR FULMINANT VIRAL HEPATITIS**, please state the sign and symptoms presented upon diagnosis?

- Jaundice Date: ..... / ..... / .....  
(DD) (MM) (YYYY)  
 Ascites Date: ..... / ..... / .....  
(DD) (MM) (YYYY)  
 Hepatic Encephalopathy Date: ..... / ..... / .....  
(DD) (MM) (YYYY)  
 Portal hypertension Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

(b) Has liver failure progress to chronic and reached the end stage?  Yes  No

(c) If YES, what is the underlying cause of chronic liver failure?

- Viral infection  Autoimmune  
 Drug misuse  Others, please specify: .....

Alcohol

(d) Has the encephalopathy a form of Wernicke's encephalopathy?  Yes  No

(e) Is the size of liver rapidly decreasing? Please provide series of ultrasound indicating the change of size.  Yes  No

(f) Is there necrosis of entire liver lobules?  Yes  No

Please describe the extent of liver necrosis & hepatocellular damage.

.....

(g) Is there deterioration of liver function? Please provide series of liver function test and liver biopsy for details matter.

Yes  No

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. liver biopsy, liver function test, hepatitis viral serology test, ultrasound/CT scan of liver, blood and laboratory test results*

### III. Applicable for - Chronic Lung Disease

1. (a) Has the lung disease reached end stage? Please stated date of diagnosis.

Yes  No

Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

(b) What is the underlying cause of respiratory failure?

Asthma

Tuberculosis

COPD

Pulmonary fibrosis

Chronic bronchitis

Others, please specify: .....

(c) Did the patient required permanent or temporary oxygen therapy for respiratory failure?

Permanent

Temporary

(d) Is there any dyspnoea at rest?  Yes  No

(e) Please provide details of lung function test done (including date and result).

Lung Function Test	Date:	Date:	Date:	Date:
FEV1				
FVC				
Others				

(f) Please provide details of all arterial blood gas (ABG) analysis done (including dates and results)

Arterial Blood Gas Analysis	Date:	Date:	Date:	Date:
PaO2				
PaCO2				

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT scan of lung, blood and laboratory test results, other imaging report, lung function test, arterial blood gas test*

# C ATTENDING DOCTOR'S DECLARATION

I, the undersigned, certify that I have examined the above Life Assured and that I have answered the above questions are true and to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of the Attending Doctor

\_\_\_\_\_  
Name & practice stamp

Name of the Attending Doctor : .....

Official Stamp of the Attending Doctor : .....

Professional Qualification : .....

Name & Address of Hospital/Clinic :

.....  
.....

Contact No. : .....

Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

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