

**CRITICAL ILLNESS CLAIM  
- ATTENDING PHYSICIAN'S STATEMENT  
BRAIN, NERVE, BONE, JOINT, MUSCLE,  
TISSUE RELATED ILLNESS**  
(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"/> Stroke              | <input type="checkbox"/> Coma                 | <input type="checkbox"/> Encephalitis         | <input type="checkbox"/> Paralysis of Limb  |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Major Head Trauma    | <input type="checkbox"/> Benign Brain Tumour  | <input type="checkbox"/> Major Burns        |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Apallic Syndrome     | <input type="checkbox"/> Brain Surgery        | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Bacterial Meningitis | <input type="checkbox"/> Motor Neuron Disease | <input type="checkbox"/> Poliomyelitis      |

### 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.

.....  
 .....

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

- I. Applicable for - Brain - Stroke (to be complete by Neurologist), or  
 - Multiple Sclerosis (to be complete by Neurologist), or  
 - Alzheimer's Disease, or  
 - Parkinson's Disease, or  
 - Coma (to be complete by Neurologist), or  
 - Major Head Trauma (to be complete by Neurologist), or  
 - Apallic Syndrome (to be complete by Neurologist), or  
 - Bacterial Meningitis (to be complete by Neurologist), or  
 - Encephalitis (to be complete by Neurologist), or  
 - Benign Brain Tumour, or  
 - Brain Surgery

1. (a) For **Stroke**, please confirm what is the underlying cause of illness? Please tick the relevant.

and provide date of onset. Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

- Infarction  Embolisation  Arterio-venous malformation  
 Hemorrhage  Head Injury  Others, please specify: .....

(b) Did patient suffered from any neurological deficit?  Yes  No

If Yes, please state the duration of deficits. .... / .....  
(Years) (Months)

(c) Are the neurological deficit permanent with persistent clinical symptoms/sign in the rest of lifetime of patient?

Yes  No

If Yes, please state the persistent symptoms/sign.  
 .....

(d) Is the patient still on continuous follow-up/treatment?  Yes  No

Please state the LAST follow-up date Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

(e) Is the diagnosis fall under any of the following condition?

- Transient Ischemic Attack  Cerebral symptom due to migraine  
 Any reversible ischemic neurological deficit  Cerebral injury due to trauma or hypoxia  
 Vertebrobasilar ischemia  Vascular disease affecting eye or optic nerve or vestibular function



(h) What is the prognosis of the neurological impairments?

- Recovered       Stable and improving       No change, likely to be permanent

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan of brain, blood and laboratory test, neurological assessment, surgery report)

2. (a) For **Multiple Sclerosis**, please select the appropriate condition.

- Central Nervous System       Peripheral Nervous System

(b) Any impairment on co-ordination and motor sensory function?  Yes       No

If Yes, please state the symptoms and its duration.

.....

(c) Please state the extent of neurological deficits and its duration in details. .... / .....  
(Years) (Months)

.....

.....

(d) Any history of multiple exacerbations and remissions?  Yes       No

If Yes, please indicate number of each with dates. ....

(e) Any evidence of multiplicity or discrete lesion on imaging studies? If Yes, please provide copies of reports.

- Yes       No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan of brain, blood and laboratory test, neurological assessment, surgery report)

3. (a) For **Alzheimer's Disease**, please state the underlying cause of dementia.

- Alzheimer's Disease       Drug related organic disorder  
 Vascular Dementia       Alcohol related organic disorder  
 Neurosis or psychiatric illness       Others, please specify: .....

(b) Please confirm the stage of Alzheimer's Disease:

- Stage 1: Normal outward behaviour       Stage 5: Moderately severe decline  
 Stage 2: Very mild changes       Stage 6: Severe decline  
 Stage 3: Mild decline       Stage 7: Very severe decline  
 Stage 4: Moderate decline

(c) Any significant reduction in mental and social functioning?

- i. Deterioration or loss of intellectual capacity  Yes       No  
ii. Abnormal behaviour  Yes       No

(d) Please state the scores of Mini Mental State Examination (MMSE) or any equivalent test done.

.....

(e) Whether the patient required any continuous supervision?  Yes       No

If Yes, please specify .....

(f) Was the disease permanent and irreversible?  Yes       No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, neurological assessment, MMSE and all supporting clinical questionnaires, cerebral angiogram)



6. (a) For **Major Head Trauma**, please stated the exact date of injury. Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

(b) Please give details of the circumstance leading to the injury?  
 .....

(c) Please provide exact location and extent of head injury.  
 .....

(d) Was any surgery performed on the head injury?  Yes  No

If Yes, please specify: .....

(e) Was any functional impairment resulting from head injury?  Yes  No

If Yes, please specify in details and its lasting duration:  
 .....

(f) Was the impairment expected to be permanent and beyonce any hope of recovery based on current medical knowledge and technology?

Yes  No

(g) Activities of Daily Living Assessment: Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continenence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, neurological assessment, biopsy, surgery report, police report)*

7. (a) For **Apallic Syndrome**, is there presence of universal necrosis of the brain cortex with the brainstem remaining intact?

Yes  No

If Yes, please specify in details including its neurological deficits.  
 .....

(b) Has the condition been medically documents and persisted for at least one month since onset?

Yes  No

If Yes, please specify in details and its duration with supporting medical reports (etc: EEG).  
 .....

(c) Please stated the medical treatment/surgery given or any treatment planned in future.  
 .....

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, EEG report)*



(g) Has the tumour been surgically removed either partially or totally?  Yes  No

If Yes, please state the date of surgery and its approach:

.....

(h) Was the illness fall under any of following condition?

- i. Cyst  Yes  No
- ii. Granulomas  Yes  No
- iii. Malformations in or of the arteries or veins of the brain  Yes  No
- iv. Haematomas  Yes  No
- v. Tumors in the pituitary gland, or spine  Yes  No
- vi. Tumors of the acoustic nerve  Yes  No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, biopsy)

10. (a) For **Brain Surgery**, was the surgery performed under general anesthesia and involved opening of skull?

Yes  No

If Yes, please state the exact date of operation. Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

(b) What is the circumstance leading to the surgery?

Illness  Accident

(c) Please stated the approach of surgical/procedure that performed.

- i. Craniotomy  Yes  No
- ii. Burr hole procedures  Yes  No
- iii. Transphenoidal procedures  Yes  No
- iv. Endoscopic assisted procedures  Yes  No
- v. Others minimally invasive procedures  Yes  No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, biopsy)

## II. Applicable for Nerve - Motor Neuron Disease (to be complete by Neurologist)

1. (a) For Motor Neuron Disease, please indicated characteristic of the illness.

- degenerative of corticospinal tract  degenerative of bulbar efferent neurons
- degenerative of anterior horn cells  Others, please specify: .....

(b) Please stated the types of motor neuron disease.

- Spinal Muscular Atrophy  Primary Lateral Sclerosis
- Progressive Bulbar Palsy  Others, please specify: .....
- Amytrophic Lateral Sclerosis

(c) Was there any permanent neurological deficit with persisted clinical symptoms (etc: sensory, motor, autonomic)?

Yes  No

If Yes, please specify: .....

(d) Please stated the medical treatment/surgery given or any treatment planned in future.

.....

(e) Any signs of progressive impairment?  Yes  No

If Yes, please provide details: .....

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, biopsy, electromyography, nerve conduction studies, CSF studies)



- III. Applicable for - Bone, Joint, Muscle, Tissue - Paralysis of Limb  
 - Major Burns  
 - Muscular Dystrophy (to be complete by Neurologist)  
 - Poliomyelitis (to be complete by Neurologist)

1. (a) For **Paralysis of Limb**, please state the underlying cause of condition.

Illness       Accident

(b) If caused by Illness, please specify in details.

.....

If caused by Accident, please provide accident details (date, time, how accident happened)

.....

(c) Was the loss of use of function involve at least 2 or more limbs?     Yes       No

Please specify in details: .....

(d) Please state the condition of illness and its duration involved.      Date: ..... / ..... / .....  
(DD)                                  (MM)                                  (YYYY)

Complete & Permanent       Partial & Temporary

(e) Examination of muscle power and range of movement of limbs with maximum grade of 5 being the highest.

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

Upper Limbs	Muscle Power		Range of Movement	
	Left	Right	Left	Right
Shoulder				
Elbow				
Wrist				
Grip				
<b>Lower Limbs</b>				
Hip				
Knee				
Ankle				

(f) **Activities of Daily Living Assessment:**      Date: ..... / ..... / .....  
(DD)                                  (MM)                                  (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continenence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, neurological assessment)*

2. (a) For **Major Burn**, please provide details of incident/accident (date, time, how was it happened)

.....

(b) Was the burn due to self-inflicted?  Yes  No

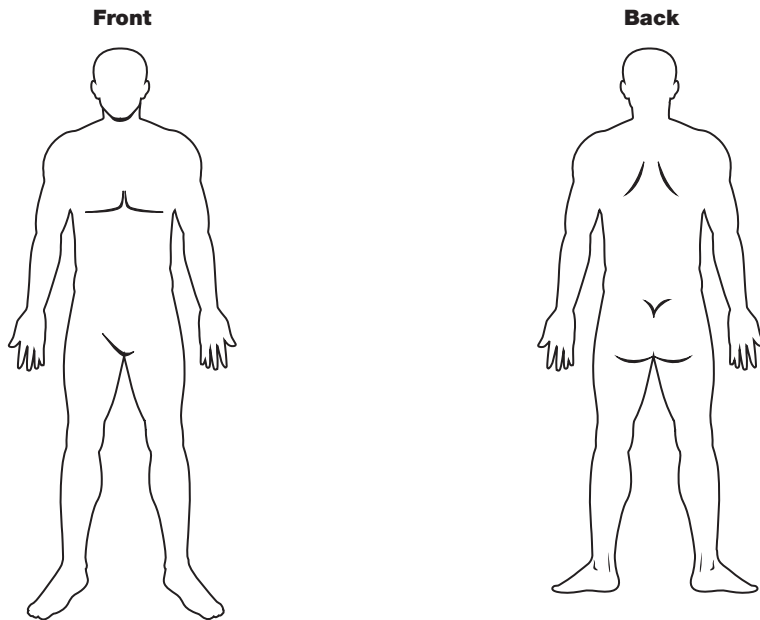
(c) Please state the extent of burn in terms of depth and size (percentage of affected body surface area by "The Rule of 9" of Lund & Browder Body Surface Chart.

Depth of Burn	Affected body surface area and its percentage
First Degree	
Second Degree	
Third Degree	
Fourth Degree	

(d) Any skin grafting done or in scheduled?  Yes  No

If Yes, please indicate date of surgery. Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

(e) Please indicate the burnt areas on the Total Body Surface Area Burns Assessment Figure. (Please provide copy of the report for its supporting). Kindly highlight all the burnt areas and specify the areas with Third Degree Burns



*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report, Lund & Browder Body Surface Chart Radiological, police report)*

3. (a) For **Muscular Dystrophy**, please stated the type of illness.

- Duchenne's
- Facioscapulohumeral
- Myotonic
- Congenital
- Others, please specify: .....

(b) Are the neurological deficits likely to be permanent and beyonce any hope of recovery?

Yes  No

If Yes, please specify in details: .....

(c) Was any clinical presentation including ABSENCE of sensory disturbance, normal cerebro-spinal fluid or mild tendon reflex reduction?

Yes  No

If Yes, please specify in details: .....

(d) Was there wasting or weakness of muscles? (Please state the power of affected muscles with score 1 being the lowest & 5 being the highest)

Date	Affected muscles & muscle power

(e) Activities of Daily Living Assessment: Date: ..... / ..... / .....  
(DD) (MM) (YYYY)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer - Getting in & out of a chair without physical assistance			
Mobility - Ability to move from room to room without physical assistance			
Continence - Ability to control bowel & bladder function as to maintain personal hygiene			
Dressing - Putting on & taking off clothing without assistance of another			
Bathing/Washing - Ability to wash in bath/shower, including getting in & out of bath or wash by other means without assistance of another			
Eating - All task of getting food into body without assistance of another			

(f) Any investigation tests done to confirm the diagnosis? Please provide copy of the report for its supporting.

Electromyogram     Muscle Biopsy     Others, please specify: .....

(g) Was there any family history of similar or related illness?  Yes     No

If Yes, please state the relationship, nature of illness & date of first diagnosed.

.....

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, neurological assessment, biopsy, electromyogram)*

4. (a) For **Poliomyelitis**, was Paralysis involved due to the illness?  Yes     No

If Yes, please specify the extent of Paralysis and its muscle power.

.....

(b) Was there any evidence of impaired motor function or respiratory weakness?  Yes     No

If Yes, please specify: .....

(c) What is the underlying cause of Paralysis?

Polio Virus                       Congenital  
 Guillain-Barre Syndrome     Others, please specify: .....  
 Injury

(d) Please state the medical treatment/surgery given or any treatment planned in future.

.....

(e) Was there any factor in patient's habits, family history or personal medical history increase risk of Poliomyelitis?

Yes     No

If Yes, please specify: .....

*Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. CT/MRI scan, blood and laboratory test, surgery report)*

# 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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