Manulife

CRITICAL ILLNESS CLAIM
- ATTENDING PHYSICIAN'S STATEMENT
CANCER
(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)

- ☐ Cancer
- ☐ Early Stage Cancer (prostate/thyroid/bladder)
- ☐ Carcinoma-in-situ
- ☐ Mastectomy for carcinoma-in situ of breast
- ☐ Prostectomy for Early Stage Prostate Cancer

Patient's Particulars

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 ILLNESSESS)

1. Are you the patient's regular/family doctor?	☐ **Yes** ☐ **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.

Sign & Symptoms	Duration

Where is the source of this information?

- ☐ **Patient**
- ☐ **Referring Doctor (Name of doctor and hospital/clinic)** .....
- ☐ **Others, please specify:** .....

4. Please describe the full and exact diagnosis with investigation/test taken and treatment given.

Date (dd/mm/yyyy)	Diagnosis	Type of investigation/test	Treatment

5. Date when the patient was informed of the diagnosis.	**Date:** ..... /..... /..... (DD) (MM) (YYYY)

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6. **Has the patient ever suffered from or detected to have raised tumour marker, abnormal PAP smear, benign tumour, pre-malignant condition, cancer, hypertension, diabetes, hyperlipidaemia, cardiovascular disease or any 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. **Are you aware of any members of your patient's close family who have suffered from this or any similar condition?**

.....

.....

8. **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**
- **Cancer, or**
- **Early Stage Cancer, or**
- **Carcinoma In Situ**
- **Mastectomy for carcinoma-in situ of breast**
- **Prostectomy for Early Stage Prostate Cancer**

1. (a) **Please describe the full and exact diagnosis**

.....

.....

(b) **Please state the exact site or organ involved.**

.....

(c) **What was the precise histology of the tumour?**

.....

(d) **What was the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TNM, FIGO, ANJJ, Ann Arbor's, Duke's etc.)**

.....

(e) **Type of investigation/ tests done to confirm the diagnosis.**

☐ Biopsy/Histopathology
☐ Bone marrow aspiration/Trephine
☐ Others, please specify: .....
☐ Tumour marker test
☐ Ultrasound/CT scan
☐ Blood test

(f) **Please provide reason if biopsy/ histology not performed.**

.....

.....

2. **Please confirm the classification of the illness:**

☐ Pre-malignant
☐ Non-invasive
☐ Carcinoma-In-Situ
☐ Malignancy
☐ Invasive
☐ Having borderline malignancy
☐ Having malignancy potential

3. **Please confirm for the following and provide details.**

- ☐ Invasive to adjacent tissues
- ☐ Completely localized
- ☐ Involved regional lymph nodes
- ☐ Others, please specify: .....

4. **Is the diagnosis fall within any of the following condition(s)?**

- ☐ T1N0M0 Urinary Bladder Cancer
- ☐ Papillary Carcinoma of Bladder
- ☐ Malignant Melanoma
- ☐ Skin Cancer
- ☐ Stage 1 Hodgkin's Disease
- ☐ Tumour manifesting as complication of AIDS/HIV
- ☐ Stage 1 Prostate Cancer
- ☐ T1N0M0 Thyroid Cancer
- ☐ Chronic Lymphocytic Leukemia less than RAI Stage 3
- ☐ Others, please specify: .....

5. **Please provide full details of all treatment provided.**

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

6. **Is the cancer condition related to the exposure of radioactive substances or radiation?**

☐ Yes ☐ No

If Yes, please provide details.

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.....

7. **Is the cancer condition newly diagnosed or recurrent?**

☐ Newly diagnosed ☐ Recurrent diagnosed

If this is recurrent case, please provide the follwing details.

Diagnosis Date (dd/mm/yyyy)	Final Diagnosis	Treatment

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. HPE/biopsy report, bone marrow aspiration/trephine biopsy report, surgical report, CT scan/MRI/radiological report, blood and laboratory 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 :

.....

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Contact No. : .....

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

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