

**CRITICAL ILLNESS CLAIM
- ATTENDING PHYSICIAN'S STATEMENT
HEART 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"/> Heart Attack/Acute Myocardial Infarction | <input type="checkbox"/> Cardiomyopathy |
| <input type="checkbox"/> Serious Coronary Artery Disease | <input type="checkbox"/> Primary Pulmonary Arterial Hypertension |
| <input type="checkbox"/> Coronary Artery Bypass Surgery | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Angioplasty and Other Invasive Treat for Coronary Artery Disease | <input type="checkbox"/> Surgery to Aorta |

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.			
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.			
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 ILLNESSESS only)

- I. Applicable for - Heart Attack/Acute Myocardial Infarction, or
 - Serious Coronary Artery Disease, or
 - Coronary Artery Bypass Surgery, or
 - Angioplasty and Other Invasive Treat for Coronary Artery Disease, or
 - Cardiomyopathy, or
 - Primary Pulmonary Arterial Hypertension

1. For Heart Attack/Acute Myocardial Infarction, please provide details of investigation/ test done to confirm the diagnosis.

Type of Investigation/Test	Date & Time	Investigation results
Cardiac enzyme marker (CK/CPKMB, Troponin T or I)		
ECG/Stress Test		
Echocardiogram		
Coronary angiogram		
Others		

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), and others)

2. For Serious Coronary Artery Disease, Coronary Artery Bypass Surgery, Angioplasty and Other Invasive Treat for Coronary Artery Disease

(a) Was coronary arteriography performed Yes No

(b) Please indicate degree of narrowing (%) of involved artery and date of diagnosis.

Artery	Date of diagnosis	% of narrowing
Left Main Stem (LMS)		
Left Anterior Descending Artery (LAD)		
Right Coronary Artery (RCA)		
Left Circumflex		
Others		

(c) Please provide details of procedure/surgery performed:

Procedure/Surgery	Date & time of Surgery	Name of Surgeon	Name of hospital	Details of surgery
<input type="checkbox"/> Coronary Bypass Graft Surgery				<input type="checkbox"/> Open Chest (e.g. thoracotomy, sternotomy) <input type="checkbox"/> Minimally invasive techniques (e.g. thoracoscopic, keyhole) <input type="checkbox"/> Others, please specify:
<input type="checkbox"/> Ballon Angioplasty				
<input type="checkbox"/> Coronary Atherectomy				
<input type="checkbox"/> Laser Treatment				
<input type="checkbox"/> Keyhole Coronary Bypass Surgery				
<input type="checkbox"/> Other form				

(d) Is this the first time patient underwent any of the above procedures? Yes No

If No, please provide history of procedures done (date and type of procedures)

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Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, operation surgery report, and others)

3. For Cardiomyopathy or Primary Pulmonary Arterial Hypertension:

(a) Please stated any heart failure/cardiac impairment at present. Yes No

If Yes, please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification

Class I Class II Class III Class IV

(b) Please describe in details the current limitation/physical impairment.

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(c) The Cardiac impairment likely to be permanent? Yes No

(d) Details of investigation performed to confirm the diagnosis.

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(e) What is the underlying cause of cardiomyopathy/pulmonary hypertension.

Coronary Artery Disease Alcohol misuse Drug abuse

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), cardiac catheterization and others)

**II. Applicable for - Heart Valve Replacement, or
- Surgery to Aorta**

1. For Heart Valve Replacement:

(a) Please provide details of diagnosis including part of cardiac structure and type of defect involved.

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(b) Any echocardiogram or other test done to confirm the diagnosis? Yes No

If Yes, please provide details of test results.

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(c) Please state purpose and details of the surgery performed

Repair valvular defect(s) Replace damaged heart valve(s)

Surgery date (dd/mm/yyyy)	Type of surgery	Name of surgeon	Name of hospital

(d) Please select the appropriate surgery approach.

Thoracotomy Key-hole Valvotomy Intra-arterial

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), and others)

2. For Surgery to Aorta:

(a) Please state the exact location of the aortic lesion.

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(b) Any echocardiogram or other test done to confirm the diagnosis? Yes No

If Yes, please provide details of test results.

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(c) The surgery was performed to correct for:

Aneurysm Dissection Obstruction
 Coarctation Others, please specify:

(d) Please provide details of surgery:

Surgery date (dd/mm/yyyy)	Exact location of aortic lesion	Name of surgeon	Name of hospital

(e) Please select the appropriate surgery approach.

Thoracotomy Laparotomy Catheter based technique
 Key-hole Intra-arterial Laser procedure

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. ECG, stress test, echocardiogram, coronary angiogram, cardiac enzyme assay (CKMB, Troponin T), and others)

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)