

**CRITICAL ILLNESS CLAIM
- ATTENDING PHYSICIAN'S STATEMENT
OTHER 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"/> Blindness | <input type="checkbox"/> HIV Infection due to Blood Transfusion |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Occupationally Acquired HIV Infection |
| <input type="checkbox"/> Loss of Speech | <input type="checkbox"/> Full Blown Aids |
| <input type="checkbox"/> Loss of Independent Existence | <input type="checkbox"/> Major Organ/Bone Marrow Transplant |
| <input type="checkbox"/> Terminal Illness | <input type="checkbox"/> Chronic Aplastic Anaemia |

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 - Blindness (to be complete by Ophthalmologist), or
 - Deafness, or
 - Loss of Speech, or
 - Loss of Independent Existence, or
 - Terminal Illness

1. (a) For Blindness, please state the underlying cause of illness? Please tick the relevant.

Corneal Scarring Others, please specify:

Optic Nerve Atrophy

(b) What is the visual acuity of noth eyes during last consultation (measured by Snellen Eye Chart or any equivalent test)

Yes No

Date of consultation	Visual Acuity	Visual Field
	Left Eye (Uncorrected):	Left Eye (Uncorrected):
	Right Eye (Uncorrected):	Right Eye (Uncorrected):
	Left Eye (Corrected):	Left Eye (Corrected):
	Right Eye (Corrected):	Right Eye (Corrected):

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

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(d) Was the loss of sight permanent and irreversible?

i. Left Eye Yes No

ii. Right Eye Yes No

(e) Was any surgical intervention or treatment based on current medical technology and knowledge that could reinstate vision of eye(s)?

Yes No

Please Yes, please specify:

(f) Was there any factor in patient's habits, family history, occupational hazards or personal medical history increase risk of Blindness?

Yes No

Please Yes, please specify:

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

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

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(h) Please provide the prognosis of illness.

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, audiometry, sound threshold test, blood and laboratory test)

3. (a) For **Loss of Speech**, please state the underlying cause of diagnosis?

- Illness Accident

Please specify in details

(b) Was the inability of speak related to illness or injury to vocal cord? Yes No

If Yes, please specify

(c) Please confirm the loss of speech condition and its duration

- i. Total Yes No Date: / /
(DD) (MM) (YYYY)
- ii. Permanent Yes No Date: / /
(DD) (MM) (YYYY)
- iii. Irrecoverable Yes No Date: / /
(DD) (MM) (YYYY)
- iv. Psychiatric related Yes No Date: / /
(DD) (MM) (YYYY)

(d) Was any surgical intervention, or treatment based on current medical technology and knowledge that could reinstate the speaking ability?

- Yes No

If Yes, please specify

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

- Yes No

If Yes, please specify

(f) Was there any family history of similar or related illness?

- Yes No

If Yes, please specify

(g) Please provide the prognosis of illness.

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, medical evidence to confirm illness or injury to vocal cord, blood and laboratory test)

4. (a) For **Loss of Independent Existence**, please state the underlying of the condition.

- Illness Accident

Please specify in details

(b) Please describe the latest physical or mental impairment based on consultation date.

Date	Physical or Mental Impairment

(c) Please provide details of completed, current or planned treatment for the illness.

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(d) Was there any completed or planned surgery for the illness? Yes No

If Yes, please specify with date and details of surgery performed.

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(e) Was patient bedridden? Yes No
 If Yes, please state its duration. Date: / /
(DD) (MM) (YYYY)

(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			
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			

(g) Please state the duration of inability. Date: / /
(DD) (MM) (YYYY)

(h) Was any surgical intervention, or treatment based on current medical knowledge and technology that could reinstate the inability?
 Yes No
 If Yes, please specify

(i) Was the inability permanent and beyonce any hope of recovery? Yes No

(j) What is the prognosis of the illness?
 Retrogressed Improving Static Recovered

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, neurological assessment, blood and laboratory test)

5. (a) For **Terminal Illness**, please provide symptoms, date of consultation, diagnosis.

Date (dd/mm/yyyy)	Symptoms	Date of consultation	Diagnosis

(b) Was the condition incurable and beyonce any hope of recovery? Yes No

(c) Was the condition reached terminal stage based on your opinion? Yes No

(d) What is the estimated life expectancy based on your opinion with justification.

(e) What is the current treatment given to patient and its effectiveness.

(f) Was active therapy been ceased or rejected in favour of palliative care? Yes No
 If Yes, please specify

(g) Was patient ever been tested positive for HIV or AIDS; or awaiting for the test results? Yes No
 If Yes, please specify

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. imaging report, radiological report, surgical/procedural report, blood and laboratory test)

**II. Applicable for - HIV Infection due to Blood Transfusion, or
- Occupationally Acquired HIV Infection, or
- Full Blown Aids**

1. (a) Please stated how did the patient contract to HIV infection.

i. Intravenous drug use Yes No

ii. Sexual activity Yes No

If Yes, please indicate patient is homosexual, multiple sexual partner, sexual worker or spouse with HIV infection

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iii. Blood transfusion Yes No

iv. Maternal-fetal transmissiom Yes No

v. Occupational exposure Yes No

If Yes for Occupational exposure, please stated below in details:

Actual Occupation	
Place of Work	
Details of the incident	
Details of post-exposure management	

vi. Haemophilia Yes No

vii. Others, please specify

(b) How did the patient become aware of the HIV positive status?

Incidental findings Symptomatic. Please specify in details with onset date

(c) Was any HIV antibody/Western Blot/CD4 cell count test done before the incident? Yes No

If Yes, please attached a copy of the said report.

(d) Was any HIV antibody/Western Blot/CD4 cell count test done after the incident? Yes No

If Yes, please attached a copy of the said report.

(e) If the HIV infection contracted through blood transfusion, please state date and reason for blood transfusion.

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(f) Was the blood transfusion medically necessary or given part of the treatment? Yes No

If Yes, please specify in details

(g) Was the blood transfusion received in Malaysia ot Singapore? Yes No

(h) Was the source of HIV infection (through blood transfusion or occupational acquired) established from the hospital/clinic?

Yes No

If Yes, please stated the name and address of the Hospital/Clinic.

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(i) Was the institution able to trace the origin of the HIV tainted blood? Yes No

If Yes, please specify

(j) Any statement from Statutory Health Authority confirming the infection was acquired through blood transfusion or occupational injury incident?

Yes No

If Yes, please provide a copy as proof of incident.

(k) For occupatinally acquired HIV infection, please confirmed whether patient is a medical staff that registered under Ministry of Health of Malaysia.

Yes No

(I) For Full Blown Aids, please stated below appropriate condition of patient.

i. Lost of weight >10% of body weight in past 6 months Yes No

If Yes, please specify

ii. Kaposi Sarcoma Yes No

iii. Pneumocystis Cariini Pneumonia Yes No

iv. Progressive multifocal leukoencephalopathy Yes No

v. active Tuberculosis Yes No

vi. < 1000 lymphocytes (/μL) Yes No

vii. Malignant lymphoma Yes No

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. HIV antibody test before & after blood transfusion, Statement from Health Authority on proof of incident, Western Blot Test, CD4 cell count test, other investigaion blood and laboratory test)

III. Applicable for - Major Organ/Bone Marrow Transplant, or
- Chronic Aplastic Anaemia

1. (a) For Major Organ/Bone Marrow Transplant, please state full and details of condition and diagnosis that leading to the necessity of transplant surgery.

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(b) Which organ involved in the transplant surgery?

Heart Lung Liver Kidney Pancreas Human Bone Marrow

Others, please specify

(c) For human bone marrow transplant, please confirm whether using hematopoietic stem cells preceded by total bone marrow ablation.

Yes No

(d) Has patient undergone the transplant surgery as a recipient? Yes No

If Yes, please provide details.

Date of surgery	Type of transplant	Doctor & Hospital Name

(e) Please state the prognosis of recovery?

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Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. radiological/ imaging report, Surgery report, blood and laboratory test)

2. (a) For **Chronic Aplastic Anaemia**, please stated the nature of bone marrow failure.

Acute Chronic and irreversible

(b) Please confirm whether the bone marroe failure leading to below condition:

i. Anaemia Yes No

ii. Neutropenia Yes No

iii. Thrombocytopenia Yes No

iv. Others, please specify

(c) Was any bone marrow biopsy done to confirm the diagnosis? Yes No

If Yes, please attached a copy of the biopsy report.

If No, please state reason for bone marrow biopsy not done.

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(e) Was any of the following treatment given?

i. Regular blood product transfusion Yes No

If Yes, please state frequency & blood product transfused.

ii. Marrow stimulating agents Yes No

If Yes, please state the medications & dosage.

iii. Immunosuppressive agents Yes No

If Yes, please state the medications & dosage.

iv. Bone marrow transplantation Yes No

If Yes, please state date of surgery and name of doctor & hospital.

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. radiological/imaging report, Surgery 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)