CRITICAL ILLNESS – OTHER ILLNESSES (BY DOCTOR)

Important Note :
Your patient is insured with us against the happening of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.
(For any medical report fee incurred in completing this form, it will be borne by the claimant)

Policy No

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1. Patient's details

Full Name	
NRIC / OLD IC / Passport No	
Occupation & exact duties	

2. Medical Record

Are you the patient's regular doctor?	☐ YES ☐ NO	If YES, since when? DD MM YY
Date the patient **FIRST** consulted you DD MM YY	Please state the symptom presented during the FIRST consultation	
Please describe FULL and EXACT diagnosis. _____ _____	Date when the illness was FIRST diagnosed DD MM YY	
Diagnosis was FIRST made by (Name of Doctor & Hospital) _____ _____	Date when patient FIRST became aware of the illness DD MM YY	

Symptoms	**Date symptom FIRST presented? (dd/mm/yy)**

Which of the following factors are present? Please provide the date of onset

Factors	**YES**	**NO**	**Date of onset (dd/mm/yy)**
Hypertension	☐	☐	
Diabetes Mellitus	☐	☐	
Hyperlipidemia	☐	☐	
Others, please specify :			

What is the source of information :

☐ Patient
☐ Referring doctor. Name of doctor & hospital / clinic : _____
☐ Others, please specify : _____

What is the underlying cause of the illness as per diagnosis above? _____ _____	
When was the underlying cause FIRST diagnosed? DD MM YY	Name of treating doctor and clinic _____ _____
Type of investigations / test done to confirm the diagnosis.	_____ _____
Please give details of completed, planned or current treatment for the illness stated above. _____ _____	What is the current condition of the Patient and what is the prognosis? _____ _____
Please provide us with any other information that will enable the Company to assess the claim.	_____ _____ _____ _____

3. Declaration & Authorization

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declaration of this claim form.

Signature and Official Stamp

Name :

Address :

Date :