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ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS (TERMINAL ILLNESS)

Name

NRIC Number

Policy Number

Claim Number

The abovenamed is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **TERMINAL ILLNESS**. To enable us to assess the claim, we would be grateful for your co-operation in the completion of this form.

A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor? ☐ Yes ☐ No

   If "YES", over what period do your records extend to?

   Start date ____ / ____ / _____ (dd / mm / yyyy) End date ____ / ____ / _____ (dd / mm / yyyy)

2. When did the patient first consult you for this condition resulting in Terminal Illness? ____ / ____ / _____ (dd / mm / yyyy)

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)

   What / who is the source of this information?

4. In your opinion, what was the likely duration of the patient's symptoms? Please provide reasons.

5. Did the patient consult any other doctors for these symptoms before he/she consulted you? ☐ Yes ☐ No

   If "YES", please provide details below.

Name of Doctor	Name of Clinic / Hospital and Address

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B. DETAILS OF CRITICAL ILLNESS

6. (a) What is the diagnosis? Please describe the full and exact diagnosis of the condition causing terminal illness.

(b) Date of diagnosis ____/ ____/ _____
dd mm yyyy

(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

(d) Date when patient was first made aware of the illness/ condition ____ / ____ / _____
dd mm yyyy

(e) Date when patient was first made aware that the illness/ condition was terminal ____ / ____ / _____
dd mm yyyy

7. Is the Terminal Illness in the presence of Human Immunodeficiency Virus (HIV) infection? ☐ Yes ☐ No

If "YES", please give the date of diagnosis for HIV and attach a copy of the HIV blood test report (if any)

8. Please provide full details of current symptoms and treatment. What is the expected impact on the patient's survival?

9. What is the prognosis?

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10. Has active treatment and therapy now been rejected in favour of relief of symptoms? ☐ Yes ☐ No

If "YES", please give details why this opinion or course of action is taken?

11. In your opinion,

(a) How long is the life expectancy of the patient? _____ Months

Please explain and give supporting medical evidence to substantiate your opinion?

(b) Is the patient's condition incurable and beyond any hope of recovery? ☐ Yes ☐ No

(c) Is the advent of death highly probable within 6 months from date of diagnosis? ☐ Yes ☐ No

(d) Is the advent of death highly probable within 12 months from date of diagnosis? ☐ Yes ☐ No

(e) Is the patient currently an in-patient in a hospital, nursing home or hospice? ☐ Yes ☐ No

12. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g., resting ECGs, exercise stress tests, surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

13. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

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C. MEDICAL HISTORY

14. Has the patient previously suffered from the condition specified above or any related illnesses?

☐ Yes ☐ No

If "YES", please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor and source of information.

15. Is there anything in the patient's medical history which would have increased the risk of the condition resulting in Terminal Illness?

☐ Yes ☐ No

If "YES", please provide details including the date of diagnosis, name and address of attending doctor and source of information.

16. Please give details of the patient's family history, which would have increased the risk of the condition resulting in Terminal Illness (including the relationship, nature of illness, date of diagnosis and source of information).

17. Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

18. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information.

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19. Does the patient have or ever had any other significant health condition(s)? ☐ Yes ☐ No

If "YES", please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor and source of information.

D. ADDITIONAL INFORMATION

20. Please provide us with any other additional information that will enable the Company to assess this claim.

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)