
**ATTENDING PHYSICIAN'S STATEMENT
MAJOR DISEASE / CRITICAL ILLNESS
CANCER/MAJOR CANCER**

Patient's Name

Attending Physician's Name

Address

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **CANCER / MAJOR CANCER**. To enable us to assess the claim, we would be grateful for your cooperation 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? ____ / ____ / ____
 dd mm yyyy

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

Symptoms Presented at First Consultation	Date Symptoms First Started

What / Who is the source of this information? _____

4. In your opinion what were the likely durations 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

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

6. (a) What is the diagnosis? Please provide full details of the diagnosis.

(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.

Name of Doctor	Name of Clinic/ Hospital and Address

(d) Date when patient was first made aware of the diagnosis? _____ / _____ / _____
 dd mm yyyy

(e) Was the patient admitted in the hospital? Yes No

If yes, please provide the following details.

Name / Address of Hospital _____

Date of Admission _____ Date Discharged _____ No. of Days _____

7. (a) What was the site or organ involved?

(b) What is the histological diagnosis of the disease? Please provide histology of the tumor.

(c) What is the staging of the tumor? Please provide full details using appropriate staging classification?
(e.g. TNM Classification, etc.)

- i. Was the disease completely localized? Yes No
- ii. Was there invasion of adjacent tissues? Yes No
- iii. Were regional lymph nodes involved? Yes No
- iv. Were there distant metastases? If yes, please provide full details, including site of any metastases, etc. Yes No

(d) If the diagnosis is leukemia, please provide details of actual type.

(e) In the case of a malignant melanoma, please give full details of size, thickness (Breslow Classification) and depth of invasion.

8. Please provide full details of all treatment provided (e.g. surgery, chemotherapy, radiotherapy, etc.), including dates and duration of each treatment.

9. Was biopsy of the tumor performed? Yes No

If yes, what was the result? _____

10. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports.

11. 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.

C. MEDICAL HISTORY

12. Has the patient ever had any malignant, premalignant or other related conditions or risk factors? Yes No

If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor . Please state source of information. _____

13. Is there anything in the patient's medical history which would have increased the risk of Cancer? Yes No

If yes, please provide full details including the date of diagnosis, name and address of attending doctor. Please state source of information. _____

14. Please give details of the patient's family history, which would have increased the risk of cancer (including relationship to the patient, nature of illness, date of diagnosis. Please state source of information. _____

15. 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. Please state source of information. _____

16. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. _____

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

D. OTHERS

18. Is the condition carcinoma-in-situ? Yes No
19. Is the condition premalignant or non-invasive? Yes No
20. Is the condition Cervical Dysplasia CIN 1, CIN 2, CIN 3? Yes No
21. Is the condition Hyperkeratoses, basal cell and squamos skin cancers? Yes No
22. Is the condition melanoma of less than 1.5 mm Breslow thickness or less than Clark Level 3? Yes No

E. ADDITIONAL INFORMATION

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

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (Please print)

Degree/Specialty

Signature

Date Signed

PRC Number / PTR Number

Telephone Number (s)

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.