

Policy No.

Claim No.  
(For internal use)

To be completed by the Attending Physician at Insured's expense.

**1. PATIENT'S PARTICULARS**

Name of the patient: \_\_\_\_\_ NRIC/Passport No: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Admission No: \_\_\_\_\_ Ward No: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

**2. DETAILS OF PATIENT'S CONDITION**

***In order for a claim under this policy to be paid, the following definition must be satisfied:***

***Hysterectomy means the surgical removal of the body of the uterus, leaving the cervix, or removal of the entire uterus, either through an incision in the abdominal wall or through the vagina by a Medical Examiner. Hysterectomy due to any of the following reasons is excluded:***

- (i) miscarriage***
- (ii) therapeutic or elective abortion***
- (iii) embedded intrauterine device or any other contraception means***
- (iv) bleeding after intercourse***
- (v) sex change***

(a) Please describe the exact details of the patient's condition.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) Date you were first consulted for the condition: dd \_\_\_\_ / mm \_\_\_\_ / yyyy \_\_\_\_

(c) What symptoms did the patient complain of when she first saw you for this condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(d) According to the patient, how long has she been experiencing these symptoms?

\_\_\_\_\_  
\_\_\_\_\_



- (q) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

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### 3. MEDICAL HISTORY

- (a) If the patient was referred from a clinic or hospital, please state:

- (i) Name of referral doctor: \_\_\_\_\_  
(ii) Name of clinic/ hospital: \_\_\_\_\_  
(iii) Date referred: \_\_\_\_\_

- (b) Did the patient consult other doctors for this illness or its symptoms before she consulted you?

Yes  No

If yes, please provide the name(s) and address(es) of the doctor(s) whom she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

- (c) Is the patient suffering or has suffered from any other significant illnesses?  Yes  No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

