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ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS (CANCER / MAJOR CANCERS)

Name

NRIC Number

Policy Number (s)

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 **CANCER / MAJOR CANCERS**. 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? ____/____/ _____ 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 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

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B. DETAILS OF 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.

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

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

(b) What is the histological diagnosis of the disease (please provide histology of the tumour)?

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

(i) Was the disease completely localised? ☐ Yes ☐ No

(ii) Was there invasion of adjacent tissues? ☐ Yes ☐ No

(iii) Were regional lymph nodes involved? ☐ Yes ☐ No

(iv) Were there distant metastases? ☐ Yes ☐ No
If yes, please provide full details, including site of any metastases, etc.

(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 a biopsy of the tumour performed? ☐ Yes ☐ No

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, pre-malignant 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 and source of information.

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13. Is there anything in the patient's medical history which would have increased the risk of Cancer? If yes, please provide full details including the date of diagnosis, name and address of attending doctor and source of information. ☐ Yes ☐ No

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 and 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 and source of this information.

16. 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.

17. Does the patient have or ever had any other significant health condition(s)? If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received. ☐ Yes ☐ No

D. OTHERS

18. Is the condition carcinoma-in-situ? ☐ Yes ☐ No

19. Is the condition pre-malignant 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 squamous skin cancers? ☐ Yes ☐ No

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22.	Is the condition melanoma of less than 1.5mm Breslow thickness or less than Clark Level 3?	☐ Yes	☐ No
23.	Is the condition Prostatic cancer described as TNM classification T1 (T1a or T1b) or another equivalent or lesser classification?	☐ Yes	☐ No
24.	Is the condition Papillary Carcinoma of the Thyroid of less than 1 cm in diameter?	☐ Yes	☐ No
25.	Is the condition tumour of Urinary Bladder histologically classified as T1N0M0 (TNM classification) or lesser?	☐ Yes	☐ No
26.	Is the condition Chronic Lymphocytic Leukaemia of less than RAI Stage 3?	☐ Yes	☐ No
27.	Is the tumour in the presence of HIV infection? If yes, what is the HIV antibody status?	☐ Yes	☐ No

E. ADDITIONAL INFORMATION

28. 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)

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