ATTENDING PHYSICIAN'S STATEMENT

Critical Illness - Primary Pulmonary Arterial Hypertension / Surgery to Aorta / Severe Cardiomyopathy

To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age
Name of Assured	Sex ☐ Male ☐ Female	

Note – Please tick the relevant diagnosis

☐ Primary Pulmonary Arterial Hypertension ☐ Surgery to Aorta ☐ Severe Cardiomyopathy

I) General Information

1. (a) Are you the Assured's usual medical physician?	1. (a) ☐ Yes ☐ No
(b) If "Yes", over what period do your records extend?	(b) _____
2. (a) When were you first consulted for this illness?	2. (a) _____ (DD/MM/YYYY)
(b) What were the symptoms/complaints?	(b) _____
(c) How long had the symptoms/complaints existed :-	
(i). According to the patient?	(c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
(ii) In your medical opinion?	(ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
3. (a) Has the Assured previously suffered from this illness or any related illnesses?	3. (a) ☐ Yes ☐ No
(b) If "Yes", please give dates of consultations and the resulting diagnosis.	(b) _____
(c) Was the patient referred to you?	(c) ☐ Yes ☐ No
(i) If Yes, when?	(i) _____ (DD/MM/YYYY)
(ii). Reasons for referral?	(ii) _____
(iii). Name and address of the referral doctors.	(iii) _____
4. (a) On what date was the diagnosis made?	4. (a) _____ (DD/MM/YYYY)
(b) On what date was the Assured first made aware of it?	(b) _____ (DD/MM/YYYY)
5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	5. _____

6. Which of the following factors are present?

		Date of Onset (DD/MM/YYYY)
a) Past history of controlled hypertension	Yes / No	_____
b) Past history of uncontrolled hypertension	Yes / No	_____
c) Diabetes Mellitus	Yes / No	_____
d) Obesity	Yes / No	_____
e) Chronic smoker	Yes / No	_____
f) Heavy drinker	Yes / No	_____
g) Stress	Yes / No	_____
h) Hyperlipidaemia	Yes / No	_____

i) Others, please specify : _____

_____

II) Details of the Assured's Illness

1. Please provide full and exact details of the diagnosis.	1. _____
2. Please describe the extent of the disease (i) Primary Pulmonary Arterial Hypertension/ Severe Cardiomyopathy (a) When was the date of onset? (b) What is the cause of the disease? (c) Please confirm if Assured falls within either Class III or IV of the New York Association Classification of cardiac impairment. If Yes, please specify type and degree of impairment. (d) Has the Assured been treated for alcoholism or narcotic or drug abuse? If Yes, please provide details of Assureds alcohol consumption or narcotic use or drug use. (e) Was Cardiac Catherization carried out? If so, please give date/s and results (ii) Surgery to Aorta? (a) Date of the Onset of the Disease of the Aorta? (b) Was excision and surgical replacement of the diseased aorta with a graft with a graft performed? (c) If "Yes", please state details.	2. (i) (a) _____ (DD/MM/YYYY) (b) _____ (c) ☐ Yes ☐ Class III ☐ Class IV ☐ No (d) ☐ Yes ☐ No (e) ☐ Yes ☐ No _____ (DD/MM/YYYY (ii) (a) _____ (DD/MM/YYYY) (b) ☐ Yes ☐ No (c) _____
3. In your medical opinion, what was the cause of the pulmonary arterial hypertension?	3. _____
4. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical illness? If "Yes", please provide full details	4. ☐ Yes ☐ No
5. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	5. ☐ Yes ☐ No
6. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	6. _____

Note: (i) For Primary Pulmonary Arterial Hypertension claims, please enclose copies of all neurological reports, X-rays, ECGs, ultrasound, cardiac catherization, laboratory test pulmonary function studies, etc. and any relevant reports that are available.
(ii) For Surgery to Aorta claims, please enclose copies of all post operative reports, X-rays, CT scans, and other imaging studies, laboratory evidence, angiograms, etc. and any relevant hospital reports that are available.
(iii) For Severe Cardiomyopathy, please enclose of all reports, resting ECGs, imaging (echocardiograms) coronary angiography and relevant hospital reports

I hereby certify that I have personally examined and treated the Assured for his / her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his / her condition.

_____ Qualification _____
Signature of Attending Physician

Name & Address _____ Date _____
(Official Stamp) (DD/MM/YYYY)

_____

Contact No. _____