



**AIA PUBLIC
TAKAFUL**

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Benign Brain Tumor

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

Certificate No:		IC No:		Age:	
Name of Person Covered:				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Part I - General Information					
1. (a) Are you the Person Covered's usual medical physician? (b) If "Yes", over what period do your records extend?		1. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____			
2. (a) When were you first consulted for this illness? (b) What were the symptoms/complaints? (c) How long had the symptoms/complaints existed :- (i) According to the patient? (ii) In your medical opinion?		2. (a) _____ (MM/DD/YYYY) (b) _____ (c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s (ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s			
3. (a) Has the Person Covered previously suffered from this illness or any related illnesses? (b) If "Yes", please give dates of consultations and the resulting diagnosis. (c) Was the patient referred to you? (i) If Yes, when? (ii) Reasons for referral? (iii) Name and address of the referral doctors.		3. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ _____ (c) <input type="checkbox"/> Yes <input type="checkbox"/> No (i) _____ (MM/DD/YYYY) (ii) _____ (iii) _____			
4. (a) On what date was the diagnosis made? (b) On what date was the Person Covered first made aware of it?		4. (a) _____ (MM/DD/YYYY) (b) _____ (MM/DD/YYYY)			
5. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.		5. _____ _____			
6. Which of the following factors are present?		Date of Onset (MM/DD/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 : _____					

Part II - Details of the Person Covered's Illness

1. Please provide full and exact details of the diagnosis.	1. _____ _____ _____
2. Please describe the extent of the illness. (a) Date of the Diagnosis (b) When was the Person Covered informed of the diagnosis? (c) Please provide the detailed location of the tumor. (d) Is the tumor in the brain confirmed by imaging studies such as CT scan or MRI? If "Yes", please provide a copy of the CT scan or MRI.	2. (a) _____ (MM/DD/YYYY) (b) _____ (MM/DD/YYYY) (c) _____ _____ _____ (d) <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Was the Person Covered treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors/hospitals.	3. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____
4. Has the Person Covered suffered from/been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.	4. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____
5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	5. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____

Note: Please enclose copies of all CT scans or MRI reports and any relevant reports that are available

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

Signature of Attending Physician

Qualification: _____

Name & Address: _____
(Official Stamp)

Date: _____
(MM/DD/YYYY)

Contact No.: _____