AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Blindness/Total Loss of Sight or Deafness/Total Loss of Hearing or Loss of Speech

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: ☐ Male ☐ Female

Part I - General Information

1. (a) Are you the Person Covered'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) _____ (MM/DD/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 Person Covered 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) _____ (MM/DD/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) _____ (MM/DD/YYYY)
(b) On what date was the Person Covered first made aware of it?	(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 disease (where applicable). (i) Blindness/Total Loss of Sight (a) When was the date of onset? (b) What is the visual acuity of both eyes at present? (c) What forms of treatment were rendered? (d) What is the prognosis? (e) (i) Will further surgery improve his/her sight? (ii) If "Yes", what kind of surgery will be necessary? (ii) Deafness/Total Loss of Hearing (a) Date of Onset. (b) Was the diagnosis confirmed by an audiometric and sound-threshold test? (c) Is the Loss of Hearing total and irreversible? (d) Is the hearing loss of at least eighty (80) decibels in all frequency of hearing? (e) Can it be corrected by hearing aid/surgical/other devices? (iii) Loss of Speech (a) Date of Onset. (b) Duration of the Loss of Speech. (c) Is the Loss of Speech considered total and irrecoverable?	2. (i) (a) _____ (MM/DD/YYYY) (b) Left _____ Right _____ (c) _____ (d) _____ (e) (i) ☐ Yes ☐ No (ii) _____ (ii) (a) _____ (MM/DD/YYYY) (b) _____ (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No (e) ☐ Yes ☐ No (iii) (a) _____ (MM/DD/YYYY) (b) _____ (c) ☐ Yes ☐ No
3. What was the cause of the Blindness / Total Loss of Sight or Deafness / Total Loss of Hearing or Loss of Speech?	3. _____
4. 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.	4. ☐ Yes ☐ No _____
5. 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.	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. ☐ Yes ☐ No _____

Note: (i) For Blindness/Total Loss of Sight claims, please enclose copies of all reports including ophthalmologist's reports, visual acuity tests, CT scans and any relevant reports that are available.
(ii) For Deafness/Total Loss of Hearing claims, please enclose copies of all audiometric and sound-threshold reports, X-rays, CT scans, any other imaging studies, laboratory evidence, angiograms, etc. and any relevant hospital reports that are available.
(iii) For Loss of Speech claims, please enclose copies of all reports from (Ear, Nose and Throat) specialists, X-rays, laboratory tests, surgical reports and any relevant hospital 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.

_____ Qualification: _____
Signature of Attending Physician

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

_____

Contact No.: _____