AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT
Female Product– Tetralogy Fallot
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? (b) If "Yes", over what period do your records extend?	1. (a) ☐ Yes ☐ No (b) ____________________
2. When were you first consulted for this illness?	2. ____________________ (MM/DD/YYYY)
3. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.	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 or hospitals. ☐ Yes ☐ No

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5. How long has the condition been medically documented?

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6. When was the diagnosis made? Please state the date. ____________________(MM/DD/YYYY)

7. Please state if there is severe or total right ventricular outflow tract obstruction.

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8. Please state if there is ventricular septal defect allowing right ventricular unoxygenated blood to bypass the pulmonary artery and enter the aorta directly.

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9 Please give dates and details of any operations performed on the Person Covered. Please attach the relevant reports supporting this diagnosis.

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10. Present Condition of the Person Covered.

11. Prognosis.

12. Please state if the Person Covered has previously suffered / been treated for any other illnesses / complaints other than this condition.

13. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

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.: