## ATTENDING PHYSICIAN'S STATEMENT
## Critical Illness – Benign Brain Tumor
## 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 |

### 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 illness.<br>(a) Date of the Diagnosis<br>(b) When was the Assured informed of the diagnosis?<br>(c) Please provide the detailed location of the tumor.<br>(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.<br>(a) _____ (DD/MM/YYYY)<br>(b) _____ (DD/MM/YYYY)<br>(c) _____<br>(d) ☐ Yes ☐ No |
| 3. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors/hospitals. | 3. ☐ Yes ☐ No |
| 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. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information. | 5. ☐ Yes ☐ 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 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. _____