



**ATTENDING PHYSICIAN'S STATEMENT**

**Critical Illness – End Stage Lung Disease or Major Organ/Bone Marrow Transplant or Major Burns or Terminal Illness**

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

Policy No.	NRIC No.	Age
Name of Assured		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Note – Please tick the relevant diagnosis</b> <input type="checkbox"/> End Stage Lung Disease <input type="checkbox"/> Major Organ / Bone Marrow Transplant <input type="checkbox"/> Major Burns <input type="checkbox"/> Terminal Illness		
<b>I) General Information</b>		
1. (a) Are you the Assured'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) _____ (DD/MM/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 Assured 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) _____ (DD/MM/YYYY) (ii) _____ (iii) _____	
4. (a) On what date was the diagnosis made? (b) On what date was the Assured first made aware of it?	4. (a) _____ (DD/MM/YYYY) (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**

<p>1. Please provide full and exact details of the diagnosis.</p>	<p>1. _____ _____</p>
<p>2. Please provide full and exact of the diagnosis and etiology. (Where applicable)</p> <p>(i) End Stage Lung Disease</p> <p>(a) (i) Has the Assured's lung disease reached end-stage? (ii) If "Yes", please state the date</p> <p>(b) What is the FEV1 test result of the Assured?</p> <p>(c) (i) Is the Assured undergoing extensive and permanent oxygen therapy? (ii) If "Yes", please state the date</p> <p>(d) Dyspnea at rest?</p> <p>(ii) Major Organ Transplant</p> <p>(a) Which is the organ involved? (b) Is it irreversible end stage failure of relevant organ? (c) For human bone marrow, is it using hematopoietic stem cells preceded by total bone marrow ablation? (d) What is the date of the operation? (e) What is the prognosis?</p> <p>(iii) Major Burns</p> <p>(a) Date of Onset (b) Are the burns considered Third Degree Burns? (c) Please describe the extent of the burns (in percentage). (d) What was the cause of the major burns?</p> <p>(iv) Terminal Illness</p> <p>(a) Date of Onset (b) What is your diagnosis? (c) What is your prognosis? (d) What is your treatment? (e) In your opinion, is the condition highly likely to lead to death within 12 months?</p>	<p>2.</p> <p>(i)</p> <p>(a) (i) <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) _____ (DD/MM/YYYY)</p> <p>(b) _____</p> <p>(c) (i) <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) _____ (DD/MM/YYYY)</p> <p>(d) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii).</p> <p>(a) _____ (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) <input type="checkbox"/> Yes <input type="checkbox"/> No (d) _____ (DD/MM/YYYY) (e) _____</p> <p>(iii).</p> <p>(a) _____ (DD/MM/YYYY) (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) _____ (d) _____</p> <p>(iv).</p> <p>(a) _____ (DD/MM/YYYY) (b) _____ (c) _____ (d) _____ (e) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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.</p>	<p>3. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____</p>
<p>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.</p>	<p>4. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____</p>
<p>5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.</p>	<p>5. _____ _____</p>

**Note:** (i) For Eng Stage Lung Disease claim, please enclose copies of all reports including X-rays, blood test, other laboratory tests, cystoscopy report, pyelograms, ultrasound, biopsy reports, surgical procedures, and any relevant reports that are available.  
(ii) For Major Organ/Bone Marrow Transplant claims, please enclose copies of all neurological reports, X-rays, ECGs, Ultrasound or any other imaging studies, Laboratory tests, biopsy reports, etc, and any relevant hospital reports that are available.  
(iii) For Major Burns claims, please enclose copies of all surgical reports and any relevant hospital reports that are available.  
(iv) For Terminal illness claims, please enclose copies of all reports including radiological procedures, CT scanning, X-rays, laboratory evidence, other imaging procedures, etc. and any relevant hospital reports that is 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.

\_\_\_\_\_  
Signature of Attending Physician

Qualification \_\_\_\_\_

Name & Address \_\_\_\_\_  
(Official Stamp)

Date \_\_\_\_\_  
(DD/MM/YYYY)

Contact No. \_\_\_\_\_