AIA Bhd. (790895-D)

H

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – Parkinson's Disease or Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders

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

Note – Please tick the relevant diagnosis

☐ Parkinson's Disease ☐ Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders

I) General Information

Question	Answer
1. (a) Are you the Assured's usual medical physician? (b) If "Yes", over what period do your records extend?	1. (a) ☐ Yes ☐ 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) ☐ Yes ☐ No (b) ______________________ ______________________ (c) ☐ Yes ☐ 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?

Factor		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 : ______________________

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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 disease (i) Parkinson's Disease (a) When was the date of onset? (b) What is the diagnosis? (c) What is the cause of the disease? (ii) Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (a) Is there evidence of deterioration or loss of Intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring continuous supervision of the life Assured? If "Yes", please describe the findings. (b) Is the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric, illness, any drug or alcohol related organic disorder? If "Yes", please give details.	2. (i) (a) ____________________ (DD/MM/YYYY) (b) ____________________ (c) ____________________ (ii) (a) ☐ Yes ☐ No ____________________ ____________________ ____________________ (b) ☐ Yes ☐ No ____________________ ____________________ ____________________
3. Is the Assured able to perform the following without assistance? (a) Getting in an out of a chair without requiring physical assistance. (b) The ability to move from room to room without requiring any physical assistance. (c) The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene (d) Putting on and taking off all necessary items of clothing without requiring assistance of another person. (e) The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means. (f) All tasks of getting food into the body once it has been prepared.	3. ____________________ (a) ☐ Yes ☐ No (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No (e) ☐ Yes ☐ No (f) ☐ 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. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	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. ____________________ ____________________

Note:

(i) For Parkinson's Disease claims, please enclose copies of all neurological reports, X-rays, CT scans, and other imaging studies, laboratory evidence, cerebral angiogram and any relevant reports that is available.

(ii) For Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders claims, please enclose copies of questionnaires or test reports or any relevant hospital 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.

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Signature of Attending Physician

Qualification ____________________

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

Contact No. ____________________