

**ATTENDING PHYSICIAN'S STATEMENT****Female Product – Carcinoma-in-situ (CIS) of Cervix or Carcinoma-in-situ (CIS) of Breast****To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense**

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| Policy No. | NRIC No. | Age |
| Name of Assured | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| I) General Information | | |
| 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? a) Past history of controlled hypertension b) Past history of uncontrolled hypertension c) Diabetes Mellitus d) Obesity e) Chronic smoker f) Heavy drinker g) Stress h) Hyperlipidaemia i) Others, please specify : _____ _____ | Date of Onset (DD/MM/YYYY) Yes / No _____ Yes / No _____ Yes / No _____ Yes / No _____ Yes / No _____ Yes / No _____ Yes / No _____ Yes / No _____ Yes / No _____ | |

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| 7. How long has the condition been medically documented? | 7. _____ |
| 8. If the diagnosis was CIS of Breast / CIS of Cervix (a) Dates and results of the latest and all previous Pap Smear tests (please provide copy of cytology reports) *Applicable to CIS of Cervix only (b) Dates & results of the biopsy or cone or colposcopy with cervical biopsy (please provide copy of stopathology reports) (c) (i) When did the Assured previously receive treatment for CIS of Breast / CIS of Cervix for an abnormal smear? (ii) From whom/where? | 8. (a) _____ (DD/MM/YYYY) (b) _____ (DD/MM/YYYY) (c) (i) _____ (DD/MM/YYYY) (ii) _____ _____ |
| 9. Is the condition malignant? | 9. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Is there focal autonomous new growth of carcinomatous cells? | 10. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. (a) Is there invasion of normal tissues by the carcinomatous cells? (b) If "Yes", what is the stage of the invasion? | 11. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) _____ |
| 12. (a) Details with dates of medical treatment performed as well as current medication. (b) Was there any surgery performed? (c) If "Yes", please provide details of surgical procedure(s). | 12. (a) _____ (DD/MM/YYYY) (b) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) _____ |
| 13. Present condition of the Assured. | 13. _____ |
| 14. Prognosis. | 14. _____ |
| 15. Is the Assured HIV (Human Immunodeficiency Virus) positive? | 15. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals. | 16. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ |
| 17. Has the Assured suffered from / been treated for any other illnesses or complaints other than this condition? If "Yes", please provide full details. | 17. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ |
| 18. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information. | 18. <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ |

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. _____