AIA PUBLIC TAKAFUL

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 Person Covered's / Claimant's own expense

Certificate No:	IC No:	Age:
Name of Person Covered:		Gender: ☐ Male ☐ Female

Note - Please tick (✓) the relevant diagnosis

☐ End Stage Lung Disease ☐ Major Organ / Bone Marrow Transplant ☐ Major Burns ☐ Terminal Illness

Part I - General Information

1. (a) Are you the Person Covered'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) _____ (MM/DD/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 Person Covered 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) _____ (MM/DD/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) _____ (MM/DD/YYYY)
(b) On what date was the Person Covered first made aware of it?	(b) _____ (MM/DD/YYYY)
5. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.	5. _____

6. Which of the following factors are present?

		Date of Onset (MM/DD/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 : _____

Part II - Details of the Person Covered's Illness

1. Please provide full and exact details of the diagnosis.	1. _____
2. Please provide full and exact of the diagnosis and etiology. (Where applicable) (i) End Stage Lung Disease (a) (i) Has the Person Covered's lung disease reached end-stage? (ii) If "Yes", please state the date (b) What is the FEV1 test result of the Person Covered? (c) (i) Is the Person Covered undergoing extensive and permanent oxygen therapy? (ii) If "Yes", please state the date (d) Dyspnea at rest? (ii) Major Organ Transplant (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? (iii) Major Burns (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? (iv) Terminal Illness (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?	2. (i) (a) (i) ☐ Yes ☐ No (ii) _____ (MM/DD/YYYY) (b) _____ (c) (i) ☐ Yes ☐ No (ii) _____ (MM/DD/YYYY) (d) ☐ Yes ☐ No (ii). (a) _____ (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) _____ (MM/DD/YYYY) (e) _____ (iii). (a) _____ (MM/DD/YYYY) (b) ☐ Yes ☐ No (c) _____ (d) _____ (iv). (a) _____ (MM/DD/YYYY) (b) _____ (c) _____ (d) _____ (e) ☐ Yes ☐ No
3. Was the Person Covered 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 Person Covered 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. _____

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 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.: _____