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Attending Physician's Statement Major Disease/critical Illness Heart Valve Replacement

Pat	ient's Name						
Att	ending Physician's Name	Address					
Thi	s section must be completed by a qualified and regist	tered physician at the expense of the claimant.					
bee	e above name is insured with us against the happening of en submitted in connection with HEART VALVE REPLAC or cooperation in the completion of this form.	f certain contingent events associated with his/her health. A claim has CEMENT . To enable us to assess the claim, we would be grateful for					
A.	GENERAL INFORMATION						
1.	Are you the patient's usual medical doctor?	☐ Yes ☐ No					
	If yes, over what period do your records extend to?						
	Start date////	End date / / / / / / yyyy					
2.	When did the patient first consult you for this condition?	 					
3.	Please state symptoms presented and date symptoms first appeared.						
	Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)					
4	What / Who is the source of this information?						
4.	In your opinion what were the likely durations of the pati-	lent's symptoms? Flease provide reasons.					
5.	Did the patient consult any other doctors for these symp If yes, please provide details below.	otoms before he/she consulted you? Yes No					
	Name of Doctor	Name of Clinic/ Hospital and Address					

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

()	What is the diagnosis? Please	
(b)	Date of diagnosis	//
(c)	Please provide the name and a	address of doctor and clinic/hospital where the diagnosis was first made.
	Name of Doctor	Name of Clinic/ Hospital and Address
(d)	Date when patient was first ma	ade aware of the diagnosis. / dd mm yyyy
(e)	Was the patient admitted in the	e hospital? Yes No
(e)	Was the patient admitted in the If yes, please state name & ac	
(e)	If yes, please state name & ad	
(e)	If yes, please state name & ad	ddress of hospital
(e) (f)	If yes, please state name & accomplaint/s	
(f)	If yes, please state name & accomplaint/s Date of Admission	TimeDate of DischargeTimeDischarged mended for surgery/// ddmm/yyyy
(f) Da	If yes, please state name & accomplaint/s Date of Admission Date when patient was recommended to the complaint of the compl	Time Date of Discharge Time Discharged mended for surgery / / dd mm yyyy mality / / / No
(f)	If yes, please state name & accomplaint/s Date of Admission Date when patient was recommended the of onset of heart valve abnormed the diagnosis supported by cardial es, please provide details and at the complex of the diagnosis supported by cardial es, please provide details and at the complex of the diagnosis supported by cardial es, please provide details and at the complex of the complex	TimeDate of DischargeTime

If no, please describe the surgical procedure used to correct the heart valve abnormality.

(b)	Was the surgical procedure pe	rformed to repair the heart valve	es?	Yes	☐ No	
(c)	Was the surgical procedure pe	rformed to replace the heart val	lves?	Yes	☐ No	
(d)	Was the surgical procedure me	edically necessary?		Yes	☐ No	
(e)	Date of surgery	///	VVVV	-		
(f)	Please provide the name and a	address of doctor and clinic/hos		rformed the	surgery.	
	Name of Doctor		Name of Clinic/ Hospital and Address			
lf ye	s the patient undergone similar p es, please provide details includi gery. Please state source of info	ng date of surgery, name and a				the
lf ye	es, please provide details includi	ng date of surgery, name and a	ddress of do	octor and cli		the
lf ye	es, please provide details includi gery. Please state source of info	ng date of surgery, name and a	ddress of do	octor and cli		the
lf ye	es, please provide details includi gery. Please state source of info	ng date of surgery, name and a	ddress of do	octor and cli		the
If ye surg	es, please provide details includi gery. Please state source of info	ng date of surgery, name and a surmation. Name of Doctor / Ad	ddress of do	octor and cli		the
Plearest rays	es, please provide details includi gery. Please state source of info Date of Surgery	Name of Doctor / Ad ner treatments provided. tigations/test performed and attacardiac enzyme assays, coron	iddress of do	Name of results of aphy, echoo	Clinic/Hospital / Address any investigations performe ardiography, surgical report	d. e

Consultation		ne of Physician	Name of Cli	
MEDICAL HISTORY				
If yes, please provide	dates of consulta	m Heart Valve Disease or any ations, the resulting diagnosis	the name and add	Yes No
Date of Cons	ultation	Name of Doctor / A	ddress	Diagnosis
				attending doctor. Please state source
	full details includ			attending doctor. Please state source— Diagnosis
of information.	full details includ	ing the date of diagnosis, nar		_
of information.	full details includ	ing the date of diagnosis, nar		_
Date of Cons Please provide detail:	full details includ ultation s of the patient's 1	ing the date of diagnosis, nar Name of Doctor / A	ddress	_
Date of Cons Please provide details relationship, nature of the provide details relationship.	full details includ ultation s of the patient's f fillness, date of d	Name of Doctor / A family history, which would inclinagnosis). Please state source	creased the risk of hee of information.	Diagnosis

19.	Does the patient have or ever had any other significant health condition(s)?						
	If yes, please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information.						
	addidi. 1 ibase state soulce of illiotitiation.						
	Name of Doctor	Name of Clinic/ Hospital and Addres	Date of Consultation/Diagnosis				
D.	ADDITIONAL INFORMATION						
20.	Please provide us with any other a	dditional information that will enable the Con	npany to assess this claim.				
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				_			
l he	reby certify that the above staten	nents are true and complete to the best of	my knowledge and belief.				
	Signature Over Printed Name of Physician		Date Signed				
	-	·	•				
	0 17 1		Aller	_			
	Qualification		Address				
	PRC Number /	PTR Number	Telephone Number (s)	-			

To the Attending Physician: You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.