

Attending Physician's Statement Major Disease /Critical Illness Progressive Bulbar Palsy

Patient's Name

Attending Physician's Name

Address

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **PROGRESSIVE BULBAR PALSYP**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

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 / /
 dd mm yyyy dd mm yyyy

2. When did the patient first consult you for this condition? / /
 dd mm yyyy

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)

What / Who is the source of this information? _____

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.
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5. Did the patient consult any other doctors for these symptoms before he/she consulted you? Yes No
If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

6. (a) What is the diagnosis? Please provide full details of the diagnosis. _____

(b) Date of diagnosis _____ / _____ / _____
 dd mm yyyy

(c) Please provide full and exact details of the disease or condition causing Progressive Muscular Atrophy.

(d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/ Hospital and Address

(e) Date when patient was first made aware of the diagnosis? _____ / _____ / _____
 dd mm yyyy

7. Please provide details, including dates, of the extent of the patient's degenerative wasting of the muscles.

8. Is the disease includes the bulbar muscles as diagnosed by a consultant neurologist?

Yes No

If yes, please provide full details and name of the consultant neurologist.

9. Is the diagnosis supported by appropriate neuromuscular testing such as Electromyogram (EMG)? Yes No

If yes, please provide full details of the result and attach a copy.

10. What is the prognosis of the patient and treatment plan?

11. Please provide full details of current treatment provided.

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12. Has surgical procedure been performed? Yes No
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13. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g. resting ECGs, ultrasound, surgical reports, X-rays, MRI / CT scans, neurological reports and any other imaging studies, laboratory evidence etc., and other relevant hospital reports.
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14. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

Name of Doctor	Name of Clinic/Hospital / Address

C. MEDICAL HISTORY

15. Has the patient previously suffered from the condition specified above or any related illness? Yes No

If yes, please provide details.

16. Is there anything in the patient's medical history which would have increased the risk of Progressive Bulbar Palsy?

Yes No

If yes, please give date of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

17. Please give details of the patient's family history which would have increased the risk of having Progressive Bulbar Palsy (including the relationship, nature of illness, date of diagnosis) Please state source of information. _____
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18. Does the patient have or ever had any other significant health condition(s)? Yes No

If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

D. ADDITIONAL INFORMATION

19. Please provide us with any other additional information that will enable the Company to assess this claim.

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (Please print)

Degree/Specialty

Signature

Date Signed

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.