

Attending Physician's Statement Major Disease / Critical Illness Occupationally Acquired HIV

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 **Occupationally Acquired HIV**. 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 ____ / ____ / ____
 dd mm yyyy

End date ____ / ____ / ____
 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

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.
- _____
- _____

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) Was the sero-conversion of the HIV infection occurred within six months of the accident?

Yes No

8. Please provide full details of all treatment provided including dates and duration of each treatment.

9. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports.

10. 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.

C. MEDICAL HISTORY

11. Has the patient ever had any other related conditions or risk factors? Yes No

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

12. Does the patient have or ever had any other significant health condition(s)? Yes No

E. ADDITIONAL INFORMATION

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