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Attending Physician's Statement Major Disease/Critical Illness Aplastic Anemia

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 **APLASTIC ANEMIA.** 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. 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 the name and 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 made aware of the diagnosis? _____ / _____ / _____
dd mm yyyy

(e) Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please provide the following details.

ame / Address of Hospital _____

_____

Date of Admission _____ Date Discharged _____ No. of Days _____

7. (a) What was the cause of the disease?

_____

(b) Has there been chronic bone marrow failure resulting from anemia, neutropenia and thrombocytopenia?
If yes, please provide details.

_____

_____

(c) Which of the following treatment is required?

i. Blood product transfusion ☐ Yes ☐ No

ii. Marrow stimulating agent ☐ Yes ☐ No

iii. Immunosuppressive agents ☐ Yes ☐ No

iv. Bone marrow transplantation ☐ Yes ☐ No

_____

_____

(d) If the diagnosis is Aplastic Anemia, please provide details of actual type.

_____

_____

8. Please provide full details of all treatment provided (e.g. surgery, chemotherapy, radiotherapy, etc.), including dates and duration of each treatment.

_____

_____

9. Has surgical procedure been performed? ☐ Yes ☐ No

If yes, what was the result? _____

10. 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.

_____

_____

11. 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.

_____

_____

. **MEDICAL HISTORY**

12. Has the patient ever had any malignant, premalignant or other related conditions or risk factors? ☐ Yes ☐ o

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

_____

_____

13. Is there anything in the patient's medical history which would have increased the risk of Aplastic Anemia?

☐ Yes ☐ No

If yes, please provide full details including the date of diagnosis, name and address of attending doctor. Please state source of information. _____

_____

_____

14. Please give details of the patient's family history, which would have increased the risk of Aplastic Anemia (including relationship to the patient, nature of illness, date of diagnosis). Please state source of information. _____

15. Please give details of the patient's habits in relation to past and present smoking including the duration of smoking habits, number of cigarettes smoked per day. Please state source of information. _____

16. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. _____

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

E. ADDITIONAL INFORMATION

18. 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**
PR 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.