

ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS STROKE

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 **STROKE**. 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 (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.
- _____
- _____

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

8. (a) How long has the patient's neurological damage lasted since the initial episode? Please provide duration in hours / days weeks.

- (b) Please provide description of the neurological damage.

- (c) Is this neurological damage permanent? Yes No

- (e) Has there been a demyelination of neurological brain tissue? Yes No

9. Please provide details of all investigations/test performed and enclose copies of all reports, e.g. CT scan and MRI scan reports, other imaging studies, laboratory evidence, and other relevant hospital reports.

10. Are the investigation findings consistent with the diagnosis of Multiple Sclerosis? Yes No

If yes, please give details.

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.

Name of Doctor	Name of Clinic/ Hospital and Address

C. MEDICAL HISTORY

12. Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischemic attack, angina and other cardiovascular diseases)? Yes No

If yes, please provide details.

13. Is there anything in the patient's medical history which would have increased the risk of Stroke? Yes No

If yes, please give dates of consultations, the resulting diagnosis, the 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 having Multiple Sclerosis (including the relationship, 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

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

D. OTHERS

18. Is the brain damage due to Transient Ischemic Attack? Yes No
If yes, please provide details.

19. Is the brain damage due to an accident or injury? Yes No

If yes, please provide details.

20. Is the brain damage due to infection, vasculitis, an inflammatory disease, vascular disease affecting the eye or optic nerve?
 Yes No

If yes, please provide details.

21. Is the brain damage due to ischemic disorders of the vestibular system? Yes No

If yes, please provide details.

21. Is the brain damage due to ischemic disorders of the vestibular system? Yes No
If yes, please provide details.

E. ADDITIONAL INFORMATION

22. 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.

Signature Over Printed Name of Physician	Date Signed
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.