

ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS MAJOR BURNS

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 **MAJOR BURNS**. 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.
- _____
- _____

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 onset ____ / ____ / ____
 dd mm yyyy

(c) Date of diagnosis ____ / ____ / ____
 dd mm yyyy

(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

(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 state name & address of hospital _____

Complaint/s _____

Date of Admission _____ Time _____ Date of Discharge _____ Time _____
 Admitted Discharged

7. (a) Please describe the extent of the Major Burns.

(b) Do you consider the Major Burns as third degree burns?

Yes No

If yes, please provide basis for details.

(c) Did the Major Burns result in full thickness skin destruction of at least 20% of the total skin area of the insured's body?

Yes No

If yes, please provide basis for details.

8. Please provide details of current treatment provided.

9. What is the prognosis?

10. Please provide full details of tests and results which have been performed to establish the diagnosis of Major Burns and attach copies of all relevant hospital reports, laboratory and test results.

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 doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

C. MEDICAL HISTORY

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

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

Date of Consultation	Name of Doctor / Address	Diagnosis

13. 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

14. 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.