CRITICAL ILLNESS - STATEMENT OF MEDICAL EXAMINER

Important Notice:

- *The following named is patient with Etiqa General Insurance Berhad against the happening of certain contingents events associated with his/her health. A claim has been submitted in and to enable us to assess the claim, we would be obliged if you would complete this Statement of Medical Examiner.*
- *Any fees chargeable for the completion of this form shall be borne by the claimant.*

Details of Patient

Policy no.:			
Name of patient:			
MyKad / Army / Police / Passport no.:		Gender:	Age:
Admission Date (dd/mm/yyyy):		Discharge Date (dd/mm/yyyy):	

General

Type of Illness *(please tick whichever is applicable)*

☐ *Alzheimer's Disease*	☐ *Paralysis*	☐ *Terminal illness*	☐ *Major organ failure & transplant*
☐ *Total Blindness*	☐ *Coma*	☐ *Loss of speech*	☐ *Major burns*
☐ *Multiple sclerosis*	☐ *Loss of hearing*	☐ *Parkinson's disease*	☐ *Chronic liver disease*
☐ *Surgery to aorta*	☐ *Pulmonary arterial hypertension*	☐ *Heart bypass*	☐ *Aplastic anaemia*
☐ *Cancer*	☐ *Stroke*	☐ *Heart attack*	☐ *End stage renal failure*

Please state the exact diagnosis:				
Please provide details if there is any underlying cause of the diagnosis:				
Is the condition is a result of an accident?	☐ Yes		☐ No	
Was the Patient under the influence of alcohol / drugs at the time of accident?	☐ Yes, please state the level of alcohol/drug found in blood/urine:		☐ No	
Are you the patient's usual medical attendant?	☐ Yes, since:		☐ No	
What were the symptoms **first** presented:				
Date when **first** became aware of the symptoms:				
How long has the symptoms been present?				
Please provide details of the history of symptoms:				
Date when **first** consulted you for the symptoms:				
Date when the illness was **first** diagnosed:				
Diagnosis was **first** made by (name of physician):				

Did the patient consult other doctors for this illness or its symptoms before he/she consulted you?	Date(dd/mm/yyyy)	Name & address of physician consulted	Illness or condition consulted

Has the patient suffered from/ been treated for any other illnesses/ complaints other than this Critical Illness?	Date(dd/mm/yyyy)	Name & address of physician consulted	Treatment	Prognosis

Is there anything in the family history which would have increased the risk of the illness?	
Any other further information which in your opinion will assist us in assessing the claim?	

Specific Critical Illness Questionnaire (to be completed where applicable)

Section A: End Stage Renal Failure

Please describe the extent of the kidney failure:-

Has the renewal disease reach end-stage?	☐ Yes, please state the date (dd/mm/yyyy):		☐ No
Which kidney(s) is involved?	☐ Right	☐ Left	☐ Both
Is the patient undergoing regular peritoneal dialysis or haemodialysis?	☐ Yes, please state the date (dd/mm/yyyy):		☐ No

Please state the frequency of required dialysis per week:	
Has kidney transplant been performed?	☐ Yes, please state the date (dd/mm/yyyy) & name of hospital: ☐ No

If the patient was also diagnosed to have High Blood Pressure and/ or Diabetes, please state the recorded blood pressure or diabetes taken on him/ her starting from the first recording done:

Date (dd/mm/yyyy)	Readings of blood pressure	Date (dd/mm/yyyy)	Results for blood glucose (fasting)

Section B: Cancer

What were the site of organ involved and the histology of the tumor?	
What stage did the disease reach? Please describe by using staging classification as appropriate:	
Was it being characterized by uncontrolled growth & spread of malignant cells & invasion of tissue?	☐ Yes ☐ No
If the diagnosis is leukemia, please provide details of the actual type:	
When and was a biopsy of tumor performed?	☐ Yes, please state the date: ☐ No
Was the tumor present of a result of any human immunodeficiency virus?	☐ Yes ☐ No

Please advice the nature of treatment/ test/ procedures that has been carried out and/ or any future intention to do so:

Date (dd/mm/yyyy)	Name of hospital	Treatment	Prognosis

Section C: HeartAttack/ Heart Bypass/ Surgery to Aorta

Was there a history of typical prolonged chest pain?	☐ Yes ☐ No
Date of the **first** onset episode (dd/mm/yyyy):	
Were there any changes in the ECG indicative of myocardial infarction?	☐ Yes ☐ No
Was there a serial elevation of cardiac enzyme (CPK-MB) above normal limit?	☐ Yes, please give details: ☐ No

Date of cardiac enzyme taken (dd/mm/yyyy)	Cardiac enzyme reading	Reading of normal cardiac enzyme

Was there any radioisotope study of the heart muscle done?	☐ Yes ☐ No

Was coronary arteriography performed?

☐ Yes ☐ No

Location	Percentage (%) of stenosis
Left Anterior Descending (LAD)	
Right Coronary Artery (RCA)	
Left Circumflex Artery (LCX)	
Right Circumflex Artery (RCX)	

Was coronary bypass surgery performed? ☐ Yes ☐ No	If yes, please state the date (dd/mm/yyyy) surgery performed, the no. & sites of graft inserted:
Was angioplasty (PTCA) performed? ☐ Yes ☐ No	If yes, please state the date (dd/mm/yyyy) angioplasty (PTCA) performed & artery involved:
Was heart valve surgery performed? ☐ Yes ☐ No	If yes, please state the date (dd/mm/yyyy) surgery performed & valve involved:
Was aorta surgery performed? ☐ Yes ☐ No	If yes, please state the date (dd/mm/yyyy) surgery performed & aorta involved:

Section D: Stroke

Nature of the episode:	
Date (dd/mm/yyyy):	
Duration of symptoms:	
Date of return to normal duties:	
The present limitation:	
Physical:	
Mental:	
Date of last assessment (dd/mm/yyyy):	
Please provide details on any neurological sequelae and the period it has persisted /lasted after the date of first diagnosis made: (Please provide documented evidence of permanent neurological deficit, if any)	
Are these sequelae permanent?	
Has there been an infarction of brain tissue, cerebral hemorrhage or embolism? ☐ Yes ☐ No	If yes, please give details:
Please give details of the past and present smoking habit:	Number of sticks of cigarettes/ cigar per day:
	Duration of years of smoking habit:

Section E: Other Illnesses

Please give details types of treatment including any operations performed:			
What tests were performed to confirm the diagnosis?			
Please describe the nature of treatment and medication prescribed:			
What is the current condition of the patient and what is the prognosis?			
For **major burns**, please state the degree of burns and percentage (%) of the surface area involved:			
Last date of consultation:			
For **Coma and Paralysis**, did the patient suffer any loss of use of limbs?	☐ Yes	☐ No	
For **Parkinson's Disease**, can the condition be controlled with medication and does it show signs of progressive impairment?			
Please state the power of patient's upper and lower limbs as at last consultation date:	Limb	Power	
	Right Upper Limb		
	Left Upper Limb		
	Right Lower Limb		
	Left Lower Limb		
For **Total Blindness**, did the patient suffer any loss of eyes / total blindness?	☐ Yes	☐ No	
	Please give details on Patient's Visual Acuity as at last consultation.	Right eye	Left eye
For **Loss of Hearing**, did the patient suffer any loss of hearing?	☐ Yes	☐ No	
	Please give details on Patient's hearing as at last consultation	Right ear (db)	Left ear (db)
For **Loss of Speech**, did the patient suffer any loss of speech?	☐ Yes	☐ No	
Was the loss due to injury or disease to the vocal cords?			

For **Major Organ Failure and Transplant**, has any major organ transplant (heart, heart &lung, liver, pancreas, kidney or bone marrow) being done?	☐ Yes	☐ No
	If yes, please provide details:	
For **Multiple Sclerosis**, did the patient exhibit neurological abnormalities that have existed for a continuous period of at least six (6) months or having had at least one (1) relapse of such abnormalities? This must be evidenced by the typical symptoms of demyelination and impairment of motor and sensory functions.	☐ Yes	☐ No
	If yes, please provide details:	
For **Alzheimer's Disease**, is the patient having deterioration or loss of intellectual capacity or abnormal lbehaviour?		
For **Aplastic Anaemia**, is the patient requiring treatment with at least one of the following (blood product transfusion / marrow stimulating agents / immune suppressive agents/ bone marrow transplant)?		
For **Chronic Liver Disease**, is the condition evidenced by permanent jaundice/ ascites/ encephalopathy?		

Declaration

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the company. I also hereby certify that the above information is correct as per record from the hospital/ clinic.

Signature of Attending Physician

Clinic/ Hospital Stamp

Date:

Name of Attending Physician & Qualification

Tel. No: