Manulife

CRITICAL ILLNESS CLAIM - ATTENDING PHYSICIAN'S STATEMENT CANCER

(This form to be completed by patient's attending doctor/specialist at patient own expense)

Claim was filed for following illness: (Please tick [✔] for appropriate box)

- ☐ Cancer
- ☐ Early Stage Cancer (prostate/thyroid/bladder)
- ☐ Carcinoma-in-situ
- ☐ Mastectomy for carcinoma-in situ of breast
- ☐ Prostectomy for Early Stage Prostate Cancer

Patient's Particulars

Policy No.	1)
	2)
	3)
	4)
Name of Patient	
New IC/Old IC/Passport No/Birth Cert	
Date of Birth	

A PATIENT'S MEDICAL RECORD (THIS SECTION IS COMPULSORY TO FILL UP FOR ALL CRITICAL ILLNESSESS)

1. Are you the patient's regular/family doctor?	☐ Yes ☐ No
If yes, when did the records extend?	Date: .... /................ /.................. (DD) (MM) (YYYY)
2. Date when patient first consulted you for the illness.	Date: .... /................ /.................. (DD) (MM) (YYYY)

3. The presenting symptoms during first consultation with you and how long did the symptoms lasting.

Sign & Symptoms	Duration

Where is the source of this information?

- ☐ Patient
- ☐ Referring Doctor (Name of doctor and hospital/clinic) ....
- ☐ Others, please specify: ....

4. Please describe the full and exact diagnosis with investigation/test taken and treatment given.

Date (dd/mm/yyyy)	Diagnosis	Type of investigation/test	Treatment

5. Date when the patient was informed of the diagnosis.	Date: .... /................ /.................. (DD) (MM) (YYYY)

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6. Has the patient ever suffered from or detected to have raised tumour marker, abnormal PAP smear, benign tumour, pre-malignant condition, cancer, hypertension, diabetes, hyperlipidaemia, cardiovascular disease or any significant illnesses?

☐ Yes ☐ No

If "Yes", please provide following details:

Date of diagnosis	Illnesses	Medication/Treatment	Name of Doctor	Name and address of clinic/hospital

7. Are you aware of any members of your patient's close family who have suffered from this or any similar condition?

....

....

8. Please provide us with other information that enable the Company to assess this claim.

....

....

B (This section is only applicable for SPECIFIC CRITICAL ILLNESSESS only)

I. Applicable for
- Cancer, or
- Early Stage Cancer, or
- Carcinoma In Situ
- Mastectomy for carcinoma-in situ of breast
- Prostectomy for Early Stage Prostate Cancer

1. (a) Please describe the full and exact diagnosis

....

....

(b) Please state the exact site or organ involved.

....

(c) What was the precise histology of the tumour?

....

(d) What was the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TNM, FIGO, ANJJ, Ann Arbor's, Duke's etc.)

....

(e) Type of investigation/ tests done to confirm the diagnosis.

☐ Biopsy/Histopathology
☐ Bone marrow aspiration/Trephine
☐ Others, please specify: ....
☐ Tumour marker test
☐ Ultrasound/CT scan
☐ Blood test

(f) Please provide reason if biopsy/ histology not performed.

....

....

2. Please confirm the classification of the illness:

☐ Pre-malignant
☐ Non-invasive
☐ Carcinoma-In-Situ
☐ Malignancy
☐ Invasive
☐ Having borderline malignancy
☐ Having malignancy potential

3. Please confirm for the following and provide details.
   - [ ] Invasive to adjacent tissues
   - [ ] Completely localized
   - [ ] Involved regional lymph nodes
   - [ ] Others, please specify: ....

4. Is the diagnosis fall within any of the following condition(s)?
   - [ ] T1N0M0 Urinary Bladder Cancer
   - [ ] Papillary Carcinoma of Bladder
   - [ ] Malignant Melanoma
   - [ ] Skin Cancer
   - [ ] Stage 1 Hodgkin's Disease
   - [ ] Tumour manifesting as complication of AIDS/HIV
   - [ ] Stage 1 Prostate Cancer
   - [ ] T1N0M0 Thyroid Cancer
   - [ ] Chronic Lymphocytic Leukemia less than RAI Stage 3
   - [ ] Others, please specify: ....

5. Please provide full details of all treatment provided.

Treatment	Date (dd/mm/yyyy)	Type and details
Surgery		
Radiotherapy		
Chemotherapy		
Others, please specify.		

6. Is the cancer condition related to the exposure of radioactive substances or radiation?
   - [ ] Yes
   - [ ] No

   If Yes, please provide details.

   ....

   ....

7. Is the cancer condition newly diagnosed or recurrent?
   - [ ] Newly diagnosed
   - [ ] Recurrent diagnosed

   If this is recurrent case, please provide the follwing details.

Diagnosis Date (dd/mm/yyyy)	Final Diagnosis	Treatment

Please attach certified true copies of ALL the relevant laboratory evidences/tests available (e.g. HPE/biopsy report, bone marrow aspiration/trephine biopsy report, surgical report, CT scan/MRI/radiological report, blood and laboratory test).

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C ATTENDING DOCTOR'S DECLARATION

I, the undersigned, certify that I have examined the above Life Assured and that I have answered the above questions are true and to the best of my knowledge and belief.

Signature of the Attending Doctor

Name & practice stamp

Name of the Attending Doctor : ....

Official Stamp of the Attending Doctor : ....

Professional Qualification : ....

Name & Address of Hospital/Clinic :

....

....

Contact No. : ....

Date: .... /................ /..................
(DD) (MM) (YYYY)

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