Sun Life
永明金融

Attending Physician's Statement
Critical Illness – Stroke

PART II - To be completed by doctor at Insured's/Claimant's expense

Policy No.				
Name of Insured	ID Card No.	Age	Date of Birth	Sex

GENERAL INFORMATION

1. Are you the Insured's usual medical physician? If "yes", over what period do your records extend?	Yes ☐ No ☐
2. When were you first consulted for this illness? What were the symptoms and at that time how long had they been present?	______________ DD / MM / YY
3. Are you aware of whether the Insured had previously suffered from this illness or any related conditions?	Yes ☐ No ☐

If "yes", please provide names, addresses and dates of doctors or hospitals which the Insured has been referred and/or admitted to and the resulting diagnosis

Name of physician/facility	Address	Date of consultation / confinement period

Diagnosis:

4. On which date was the diagnosis made? On which date was the insured first made aware of it?	______________ DD / MM / YY ______________ DD / MM / YY
5. Is there anything in the insured's family history which would have increased the risk of this illness? If "yes", please give details.	Yes ☐ No ☐

6. Please provide names, addresses and dates of doctors and hospitals which the Insured has been referred and/or admitted to for diagnosis/treatment of this current episode / illness.

Name of physician/facility	Address	Date of consultation / confinement period

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DETAILS OF THE INSURED'S ILLNESS

1. Please provide full and exact details of the diagnosis.	
2. Please describe the initial episode. i. Date of the episode ii. Nature of the episode iii. Duration of acute symptoms iv. Date of return to normal activities and/or the insured's present limitations, physical and mental.	______________ DD / MM / YY ______________ DD / MM / YY
2. Please comment on any neurological sequela which lasted more than 24 hours Are these sequelae permanent?	
4. Has there been an infarction of brain tissue, cerebral haemorrhage or embolization from an extracranial source?	
5. Please enclose copies of all reports including all reports, radiological procedures, CT scanning, laboratory evidence, other imaging studies, laboratory evidence, other imaging procedures, etc. and any relevant hospital reports that are available.	
6. Please state if the Insured has suffered/been treated for any other illness(es) / complaints other than this Critical Illness.	
7. Is there any further information, which in your opinion will assist us in assessing this claim?	

I hereby certify that I have personally examined and treated the above-named Insured for the above disability and that the facts as given above represent my opinion of his/her condition.

______________________	______________________
Name of doctor and qualification	Signature and official chop
______________________	______________________
Address and telephone number	Date