Attending Physician's Statement
Critical Illness – Cancer

Sun Life 永明金融

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? Yes ☐ No ☐

   If "yes", over what period do your records extend?

2. When were you first consulted for this illness?

   _____ DD / MM / YY

   What were the symptoms and at that time how long had they been present?

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?

   _____ DD / MM / YY

   On which date was the insured first made aware of it?

   _____ DD / MM / YY

5. Is there anything in the insured's family history which would have increased the risk of this illness? Yes ☐ No ☐

   If "yes", please give details.

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, the site involved and the precise histology of the tumour. If the diagnosis is leukaemia, please give details of the actual type.	
2. Please describe the extent of the disease. i. What is the staging of the tumor? ii. Was the disease completely localized? Yes ☐ No ☐ iii. Was there regional or distant spread? Yes ☐ No ☐ iv. If yes, please describe degree of regional nodal involvement, and/or extent of distant spread?	
1. What is the nature of treatment? ☐ Surgical ☐ Radiotherapy ☐ Chemotherapy ☐ Palliative Please provide details of procedure(s):	
4. Investigations: i. Was a biopsy of the tumour performed ? Yes ☐ No ☐ ii. Please enclose copies of all reports including biopsy records, cytology reports, X-rays, CT scans, other imaging studies, laboratory evidence, surgical report, etc, and any relevant hospital reports that are available.	
5. Please state if the Insured has suffered/been treated for any other illness(es) / complaints other than this Critical Illness.	
6. 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