Attending Physician's Statement
Critical Illness – Heart Attack

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

DETAILS OF THE INSURED'S ILLNESS

1. Please provide full and exact details of the diagnosis.	
2. Please describe the heart attack. i. Date of Attack.	_____ DD / MM / YY
	Yes ☐ No ☐
ii. Was there a current history of typical ischaemic chest pain?	Yes ☐ No ☐
iii. Was there a serial elevation of cardiac enzymes (C.P.K.) documented?	Yes ☐ No ☐
iv. Were there any changes in the ECG indicative of a myocardial infarction?	Yes ☐ No ☐
v. Duration of the acute symptoms.	
vi. Date of return to normal activities and/or the Insured's present limitations, physical and mental.	_____ DD / MM / YY
3. Was there death of a portion of the heart muscle?	Yes ☐ No ☐
4. Please enclose copies of all reports including resting ECGs, exercise stress tests, enzymes assays, isotope studies, imaging (echocardiograms), coronary angiography 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

Client Service Centre
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