Attending Physician's Statement
Critical Illness – Coronary By-Pass Surgery

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

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2. Please describe the extent of the disease.

i. Which arteries are involved and what is the degree of narrowing (%) in respect of each involved artery ?

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ii. Was coronary arteriography performed? Yes ☐ No ☐

3. What is the nature of treatment? Yes ☐ No ☐

i. Was open chest surgery performed ?

If yes, state the number and sites of grafts inserted.

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ii. What other forms of treatment were rendered?

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4. Please enclose copies of all surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence, angiograms, 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.

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6. Is there any further information, which in your opinion will assist us in assessing this claim?

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Details of "YES" answers.
(Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities).

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

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