



Critical Illness Claim - Doctor's Statement
Heart Attack of Specified Severity / Cardiomyopathy / Pericardiectomy /
Cardiac Pacemaker Insertion / Cardiac Defibrillator Insertion /
Angioplasty and Other Invasive Treatment for Coronary Artery / Coronary Artery By-Pass Surgery
/ Other Serious Coronary Artery Disease / Mild Coronary Artery Disease

DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

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|--|--|--|--|--|--|--|--|--|--|
| A) Patient's Particulars | | | | | | | | | |
| Name of Patient | Gender | | | | | | | | |
| NRIC/FIN or Passport No. | Date of Birth (ddmmyyy) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| B) Patient's Medical Records | | | | | | | | | |
| 1) Please indicate the period that is documented in the hospital/clinic's record: | | | | | | | | | |
| (i) Date of First Consultation (ddmmyyy) | <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
| | | | | | | | | | |
| (ii) Date of Last Consultation (ddmmyyy) | <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
| | | | | | | | | | |
| (iii) Number of consultations during the above period: | | | | | | | | | |
| (iv) Name of hospital/clinic and reason(s) for consultations (with dates): | | | | | | | | | |
| 2) Are you the patient's usual medical doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| If "Yes", since when? (ddmmyyy) | <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| If "No", please provide name and address of the patient's regular doctor. | | | | | | | | | |
| 3) Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| If "Yes", please advise: | | | | | | | | | |
| (i) Date referred (ddmmyyy) | <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| (ii) Reason for referral: | | | | | | | | | |
| (iii) Name and address of referring doctor: | | | | | | | | | |
| If "No", please indicate how the patient came to consult at your hospital/clinic? (e.g. A&E.) | | | | | | | | | |
| 4) Have you referred the patient to any other doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| (i) Date referred (ddmmyyy) | <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| (ii) Reason for referral: | | | | | | | | | |
| (iii) Name and address of doctor referred to: | | | | | | | | | |

2) Please provide full details and results of all **investigations** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports.

3) Name and address of the doctor/ cardiologist who **First** diagnosed the patient with the condition.

4) Has the patient previously suffered from a Heart Attack or any related illnesses (e.g. hypertension, Yes No
angina or other vascular disease?
If "Yes", please advise:
Date of **First** diagnosis Exact diagnosis Name of doctor and Address of hospital/clinic

5) Has the patient suffered from **Heart Attack**? Yes No
If "No", please proceed to **Question 6**.
If "Yes", please advise:
(i) Nature of episode:

(ii) Date of initial episode (ddmmyyyy):

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(iii) Duration of acute symptoms:

(iv) Please confirm the followings:
If "**Yes**" to any question, please **elaborate** with supporting evidence including date of test and test results.

(v) Was there a current history of typical chest pain? Yes No

(vi) Were there any changes in the ECG indicative of new myocardial infarct? Yes No

If "Yes", please state whether there was any:

(a) ST elevation or depression? Yes No

(b) T wave inversion? Yes No

(c) Pathological Q waves? Yes No

(d) Left bundle branch block? Yes No

Please **attach** a copy of the ECG tracing report.

(vii) Was there a diagnostic elevation of cardiac biomarkers, such as CKMB, Troponin T or I, etc.? Yes No

If "Yes", please provide type and date of test, and test results. **Attach** a copy of the laboratory results:

| <u>Type of Cardiac biomarker</u> | <u>Date & time of test</u> <u>(before any cardiac procedure)</u> | <u>Test Results (specify the units)</u> |
|--|---|---|
| CKMB | | |
| Troponin T or I (ng/ml or ug/L or pg/ml) | | |
| Other Cardiac biomarker If "Yes", please state: | | |

| <u>Type of Cardiac biomarker</u> | <u>Date & time of test</u> <u>(after cardiac procedure, if any)</u> | <u>Test Results (specify the units)</u> |
|--|--|---|
| CKMB | | |
| Troponin T or I (ng/ml or ug/L or pg/ml) | | |
| Other Cardiac biomarker If "Yes", please state: | | |

(viii) Please advise with regard to the left ventricular ejection fraction:

(a) Was there left ventricular ejection fraction of less than 50% measured three months or more after the event? Yes No

(b) What was the left ventricular ejection fraction at initial diagnosis?

(ix) Was there death of a portion of the heart muscle? Yes No

If "Yes", please provide details:

(x) Was there imaging evidence indicating new loss of viable myocardium or new regional wall motion abnormality? Yes No

If "Yes", please elaborate with supporting evidence of imaging report(s) and name of the attending cardiologist.

(xi) Please provide details of the surgery and/or other mode of treatment that had been performed, including name and date of treatment, and name and address of attending cardiologist.

(xii) Date of return to normal activities (ddmmyyy):

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6) Has the patient suffered from **Cardiomyopathy**?

Yes No

If "No", please proceed to **Question 7**.

If "Yes", please advise:

(i) Date of **First** diagnosis of Cardiomyopathy (ddmmyyyy)

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(ii) Has the patient previously undergone any cardiac investigation (e.g. ECG, echocardiogram, CT scan, etc.)?

Yes No

If "Yes", please advise:

(a) Type of cardiac investigation done:

(b) Date of investigation (ddmmyyyy):

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Please **attach** a copy of the above investigation reports.

(i) Was the diagnosis of Cardiomyopathy made unequivocally based on cardiac echographic findings of compromised ventricular performance?

Yes No

If "Yes", please attach a copy of the echographic findings report.

If "No", please specify the basis of diagnosis:

(iv) Does the patient have any cardiac or physical impairment which fulfills the New York Heart Association (NYHA) Classification of Cardiac Impairment criteria?

Yes No

If "Yes", please describe the patient's current symptoms.

Please state the NYHA class of impairment? (delete as appropriate):

Class I / II / III / IV

- (v) Has the Cardiomyopathy resulted in permanent physical impairments of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment? Yes No

If "Yes", please circle the patient's NYHA Classification for the current condition and provide us with the full details in the table below:

| NYHA Classification *Please circle | What limitation in physical activity does the patient have? | Is the limitation of physical activity permanent? *Please circle |
|---|--|---|
| Class I: (No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain) | | Yes / No |
| Class II: (Slight limitation of physical activity. Ordinary physical activity results in Symptoms) | | Yes / No |
| Class III: (Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms) | | Yes / No |
| Class IV: (Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest) | | Yes / No |

- (vi) What was the underlying cause of the Cardiomyopathy?

7) Has the patient suffered from **Pericardial Disease**?

Yes No

If "No", please proceed to **Question 8**.

If "Yes", please advise the following:

(i) Date of **First** diagnosis of Pericardial disease (ddmmyyyy):

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(ii) Was surgery performed for the patient's pericardial disease condition?

Yes No

If "Yes", please advise:

(a) Type of surgery performed (e.g. pericardectomy, keyhole cardiac surgery, etc.):

(b) Date of surgery (ddmmyyyy):

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Please **attach** a copy of the above investigation report(s).

(iii) Was the surgery performed considered medically necessary by the consultant cardiologist?

Yes No

(iv) Was there any other mode of treatment other than the above surgery that could have been performed?

Yes No

If "Yes", please advise:

(a) Alternate mode of treatment:

(b) Reason(s) why the above alternate mode of treatment was not used.

8) Has the patient suffered from **Cardiac Arrhythmia**?

Yes No

If "No", please proceed to **Section 9**.

If "Yes", please advise:

(i) Type of cardiac arrhythmia presented:

(ii) Date of **First** diagnosis (ddmmyyyy)

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(iii) Was pathway ablation therapy attempted?

Yes No

If "Yes", please state the date of therapy (ddmmyyyy):

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If "No", why was this not done?

(iv) Was a permanent cardiac pacemaker inserted?

Yes No

If "Yes", please state the date of insertion (ddmmyyyy):

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(v) Was a permanent cardiac defibrillator inserted?

Yes No

If "Yes", please state the date of insertion (ddmmyyyy):

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(vi) Was there any other mode of treatment which could have been used to treat the patient's cardiac arrhythmia? If "Yes", please specify:

Yes No

(a) Alternate mode of treatment:

(b) Reason(s) why the above alternate mode of treatment was not used.

Please **attach** a copy of the ECG tracing.

9) Did the heart disease require **Coronary Angioplasty or similar intra-arterial catheter procedure**?

Yes No

If "No", please proceed to **Section 10**.

If "Yes", please advise:

(i) Please state type of procedure performed.

(ii) Date the procedure was performed (ddmmyyyy):

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(iii) Please specify the coronary arteries involved and the degree (%) of narrowing and **attach** a copy of **Angiogram report**.

| Coronary Artery | Stenosis | Percentage of Stenosis |
|---------------------------------|--|------------------------|
| Left Main Stem | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Left Anterior Descending Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Left Circumflex Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Right Coronary Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

(iv) Name of surgeon who performed the procedure and name of hospital in which it was performed:

(v) Please provide full details of any other treatment provided.

(vi) Was the procedure considered medically necessary by the consultant cardiologist? Yes No

(vii) Has the patient undergone a similar procedure before? Yes No
 If "Yes", please state date and place where it was performed, and the reason(s) for the procedure.

(viii) Did the patient previously suffer from coronary artery disease or any related illness? Yes No
 If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, and name and address of attending doctor.

(ix) Have any other investigative tests or procedure been performed? Yes No
 If "Yes", please provide details and attach a copy of results (e.g. angioplasty operation report, myocardial perfusion test, 2-D echocardiogram, etc).

10) Did the heart disease lead to **Surgery or Serious Coronary Artery Disease**? Yes No

If "No", please proceed to **Section D**.

If "Yes", please advise:

(i) Name and address of the **cardiologist** who **First** diagnosed the patient with this condition.

(ii) Please tick (✓) the type of surgery performed:

- Coronary Artery Bypass Surgery
- Transmyocardial Laser Revascularization
- "Keyhole" Surgery
- Atherectomy
- Enhanced External Counterpulsation
- Others (please specify):

(iii) Date the surgery was performed (ddmmyyyy):

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(iv) (a) Please specify the coronary arteries involved and the degree (%) of narrowing and **attach** a copy of **Angiogram report**.

| Coronary Artery | Stenosis | Percentage of Stenosis |
|---------------------------------|--|------------------------|
| Left Main Stem | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Left Anterior Descending Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Left Circumflex Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Right Coronary Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

(b) Was the occurrence of the mentioned stenosis of the involved coronary arteries detected in a single invasive coronary angiography report performed? Yes No

If "Yes", please advise:

Date the invasive coronary angiography performed (ddmmyyyy):

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If "No", please advise:

Dates of **ALL** invasive coronary angiography performed (ddmmyyyy):

(v) If an open chest (open heart) surgery was performed, please advise:

(a) Number of grafts:

(b) Sites of grafts inserted:

(vi) Name of surgeon(s) who performed the surgery and name of hospital in which surgery was performed.

(vii) Please provide full details of any other treatment provided.

(viii) Was the above surgery considered medically necessary by the consultant cardiologist? Yes No

(ix) Has the patient undergone a similar surgery before? Yes No

If "Yes", please provide details, including date and place of surgery, and the reasons for the surgery.

(x) Did the patient previously suffer from coronary artery disease or any related illness? Yes No

If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, and name and address of attending doctor.

(xi) Have any other investigative tests or procedure been performed? Yes No

If "Yes", please provide details and attach a copy of the results (e.g. cardiac catheterization report, myocardial perfusion test, etc.).

D) Other Information

1) Was the patient admitted to a hospital for treatment of the diagnosis?

 Yes No

If "Yes", please advise:

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| Name of the hospital | | |
| Admission Date and Time (ddmmyyyy; hh:mm) | | |
| Discharge Date and Time (ddmmyyyy; hh:mm) | | |
| Name of the hospital | | |
| Admission Date and Time (ddmmyyyy; hh:mm) | | |
| Discharge Date and Time (ddmmyyyy; hh:mm) | | |

2) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the diagnosis?

 Yes No

If "Yes", please advise:

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|--|--|--|
| Name of the hospital | | |
| Admission Date and Time (ddmmyyyy; hh:mm) | | |
| Discharge Date and Time (ddmmyyyy; hh:mm) | | |
| Name of the hospital | | |
| Admission Date and Time (ddmmyyyy; hh:mm) | | |
| Discharge Date and Time (ddmmyyyy; hh:mm) | | |

3) Is the patient's diagnosis or surgery directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? Yes No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (ddmmyyyy)

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Date the patient **First** became aware of the condition (ddmmyyyy)

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(ii) Wilful misuse of alcohol? Yes No

(iii) Wilful misuse of drugs? Yes No

(iv) Congenital anomaly or defect? Yes No

If "Yes", please provide full details including reasons for the result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and hospital/clinic where the patient was **First** diagnosed with HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

Please provide a copy of the relevant test result(s).

4) What is the prognosis of the patient's condition?

5) Is there anything in the patient's **lifestyle or personal medical history** which may have increased the risk of the condition? Yes No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis Date of diagnosis Name of doctor & address of hospital/clinic

6) Is there anything in the patient's **family history** which may have increased the risk of the condition? Yes No

If "Yes", please advise:

Relationship with patient Nature of condition Age of onset Source of information

7) Have active treatment and therapy now been rejected in favour of relief of symptoms? Yes No

If "Yes", please provide full details and explain the reason for this course of action.

8) Based on the **Last** consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:

(i) Six (6) months? Yes No

(ii) Twelve (12) months? Yes No

If "Yes" to (i) and/or (ii), please advise:

a) Medical treatment(s) that had been provided to the patient

b) Prognosis after undergoing the mentioned medical treatment(s)

c) Any other details on the basis of your evaluation.

9) Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation(s).

10) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitation(s), including the degree of cognitive and/or intellectual impairment.

11) i) Is the patient mentally incapacitated? Yes No

ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? Yes No

12) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **condition or any other related diseases**? Yes No

If "Yes", please advise:

| | | |
|--|---|---------------------------------|
| <u>Name of doctor and Address of hospital/clinic</u> | <u>Date of First & Last consultation</u> | <u>Reasons for consultation</u> |
|--|---|---------------------------------|

13) Is the patient still on follow-up at your hospital/clinic? Yes No

If "Yes", please state date of next appointment (ddmmyyy)

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If "No", please state date of discharge (ddmmyyy), if any.

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14) Has the patient **previously** had any cardiac investigation done (e.g. ECG, echocardiogram, CT scan)?

If "Yes", please provide details:

(i) Type, results and date of cardiac investigation done:

(ii) Reasons for the investigation:

(iii) Name of cardiologist and address of hospital / clinic:

15) Please provide us with any other additional information that may assist the Company in assessing this claim.

Please enclose copies of all investigation reports including specialist, hospital and laboratory reports. Where applicable, please provide the following:

- (i) Angioplasty reports
- (ii) Blood test (Creatine kinase-MB, Troponin) reports
- (iii) CABG reports
- (iv) Coronary angiogram reports
- (v) Echocardiography reports
- (vi) Exercise stress tests
- (vii) Myocardial perfusion scans
- (viii) Operation reports, surgical reports
- (ix) Referral letters (if any)
- (x) Any other investigation reports

E) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor

Address & Official Stamp of Doctor

Name of Doctor

Date (ddmmyyyy)