Life Insurance

CRITICAL ILLNESS (CANCER) – STATEMENT OF MEDICAL EXAMINER (GROUP CLAIM)

1. The following named is covered with **ETIQA LIFE INSURANCE BERHAD** against the happening of certain contingents events associated with his/her health. A claim has been submitted in connection with **CANCER** and to enable us to assess the claim, we would be obliged if you would complete this Statement of Medical Examiner
2. Any fees chargeable for the completion of this form shall be borne by the claimant.

CONTRACT NO:……

Name of Participant: ……..

NRIC/Birth Cert No/Passport No: ……..

1. (a) Are you the Participant's usual doctor? ☐ Yes ☐ No

   (b) If yes, since when the Participant has been consulting you?..... (dd/mm/yyyy)

2. (a) Date when Participant **first** consulted you for this illness?..... (dd/mm/yyyy)

   (b) What were the symptoms presented? ……

   (c) How long had symptoms been present? ……

   (d) Please state full and exact diagnosis: ……

   (e) Date when illness was **first** diagnosed: ..……..

   (f) Diagnose was **first** made by (name & address of doctor):……..

   ……

   (g) When Participant was **first** informed of the diagnosis?.....(dd/mm/yyyy)

   (h) Has the Participant suffered from this illness or any related illnesses previously? ☐ Yes ☐ No

   If yes, please state details

Date (dd/mm/yyyy)	Diagnosis	Name & address of hospital	Treatment

   (i) Please state if there is anything in the Participant's family history which would have increased the risk of illness

   ……..

   (j) What stage did the disease reach? Please describe by using whichever staging classification is appropriate

   ……..

3. (a) What was the site or organ involved and the histology of the tumour?

   ……

   (b) Was it completely localized to the tissue or organ of origin? ☐ Yes ☐ No

   (c) Was there invasion of adjacent tissues? ☐ Yes ☐ No

   (d) Was there regional or distant metastasis? ☐ Yes ☐ No

   If yes, please describe the extent of regional nodal involvement, and/or extent of distant metastasis: ……

   ……..

(e) If the diagnosis is leukaemia, please provide details of the actual type: ……

……

(f) Was a biopsy of tumour performed? ☐ Yes ☐ No

(g) If yes, when was the biopsy of tumour performed? ..... (dd/mm/yyyy)

4. Please advise the nature of treatment that has been carried out or of any future intention to do so.

Date (dd/mm/yyyy)	Treatment	Name & address of hospital	Prognosis

5. Has the Participant suffered from/been treated for any other illnesses related to / cause for this Critical Illness? ☐ Yes ☐ No

If yes, please give full details (diagnosis & date) ..……..

……

6. Did the Participant consult other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐ No

If yes, please give details

Date of attendance(dd/mm/yyyy)	Name & address of doctors/hospital	Illness or condition consulted

7. Please provide names and addresses of any hospital or clinic to which the Participant was referred together with the names of attended consultants.

……

Please furnish copies of all investigation reports, including biopsy reports, cytology reports, x-rays, CT scans, imaging studies, laboratory evidence, surgical reports, etc. and any relevant medical reports that are available.

DECLARATION

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

Signature :_____

Name of Attending Oncologist: _____ Professional Qualification(s) :_____

Name & Address of Hospital / Clinic :_____

Address :_____ Official Stamp of Hospital / Clinic

Telephone Number :_____ Fax No.: _____

E-mail :_____ Date :_____

_____