CRITICAL ILLNESS CLAIM FORM
Statement by Doctor

A. SCHEME AND EMPLOYEE DETAILS

Scheme Name: _____

Employee Details

Name: _____

Identity Number: _____ Date of Birth: _____ (DD/MM/YYYY)

B. CRITICAL ILLNESS DETAILS

Date of Diagnosis: _____ (DD/MM/YYYY)

Critical Illness:

- ☐ Cancer
- ☐ Heart Attack
- ☐ Coronary Artery Surgery
- ☐ Stroke
- ☐ Renal Failure
- ☐ Blindness
- ☐ Major Organ Transplant
- ☐ Paraplegia

When were you first consulted for the current critical illness? _____ (DD/MM/YYYY)

When were you last consulted for the current critical illness? _____ (DD/MM/YYYY)

When is the next consultation scheduled with the patient? _____ (DD/MM/YYYY)

What were your findings on initial consultation (signs, symptoms, investigations)?

_____

_____

_____

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C. DOCTOR'S DECLARATION

I certify that the above information is, to the best of my knowledge and belief, true and accurate, and that no information has been withheld, nor has any information regarding the circumstances been omitted.

Doctor's Full Name: _____

Registration Number: _____ Telephone: _____

Signature: _____ Date: _____ (DD/MM/YYYY)

Doctor's Stamp

Click to Submit

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