CRITICAL ILLNESS CLAIM FORM

Statement by Doctor

A. DETAILS

Scheme name: _____

EMPLOYEE DETAILS

Name:_____ Identity Number:_____ Date of Birth:_____

CRITICAL ILLNESS DETAILS

Date of Diagnosis: ☐

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? ☐

When were you last consulted for the current critical illness? ☐

When is the next consultation scheduled with the patient? ☐

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

:_____

:_____

B. 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: _____ Signature_____Date: _____

Click to Submit

Doctor's Stamp

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