



Dread Disease Claim - Cancer

Part II – Medical Certificate (to be completed by the Attending Physician, duly qualified and registered, at claimant's own expense) in relation to Cancer – A malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukaemia (other than chronic lymphocytic leukaemia), but excludes non-invasive cancers in-situ, tumours in the presence of any human immunodeficiency virus and any skin cancer other than malignant melanoma.

Policy No: _____

Patient Details
Name: _____ ID No: _____ Date of Birth: ___/___/___ Sex: M F

1. Are you the patient's usual medical physician? Yes No

If so, Medical records date back to ___/___/___ (YY/MM/DD)

2. When were you first consulted for this or related illness and what were the symptom(s) presented?

Date: ___/___/___ (YY/MM/DD)

Symptoms presented:

3. According to the patient, for how long have these symptoms existed?

Since ___/___/___ (YY/MM/DD) or for _____ year(s) _____ month(s) _____ day(s)

4. a) What was the clinical diagnosis

b) When was it made? ___/___/___ (YY/MM/DD)

c) Was the patient informed? Yes No

If so, By (name & address of physician):

d) In your opinion, how long has the patient suffered from this disease?

5. Please provide full details of the final diagnosis and its clinical basis of the condition leading to the treatment/surgery.

6. Was the patient referred to you by other physician? Yes No

If so, By (name & address of physician)

7. Has the patient previously suffered from the condition specified above or any related illness? Yes No

If so, please give details.

8. Is there anything in the patient's family history which would increase the risk of this illness? Yes No

If so, please give details

9. Details of the patient's cigarette smoking habits.

10. All consultants, specialist or hospitals to which your patient has been referred to or attended for this condition.

| <u>Date</u> | <u>Diagnosis</u> | <u>Hospitalizations</u> | <u>Name of Physician/Hospital</u> |
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|---|--|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| <p>11. a) What is the staging of Tumour?</p> <p>b) Was the disease completely localized? If so, details:</p> <p>c) Was there invasion of adjacent tissues? If so, details:</p> <p>d) Were regional lymph nodes involved? If so, details:</p> <p>e) Were there distant metastases? If so, details:</p> | <p>Stage : _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | | | | | | | | |
| <p>12. If the diagnosis is Leukaemia, please give details of the actual type.</p> | | | | | | | | | | |
| <p>13. Please give details of current treatment.</p> | | | | | | | | | | |
| <p>14. What is the prognosis of the patient?</p> | | | | | | | | | | |
| <p>15. Were there any tests performed before reaching the diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please enclose copies of all laboratory and pathology report, and any relevant hospital report's that are available.) If so, <u> Date </u> <u> Test </u> <u> Result/ Histopathological Diagnosis </u></p> | | | | | | | | | | |
| <p>16. Is the disease diagnosed to be directly or indirectly caused by or result from</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 45%;">self-inflicted injuries while sane or insane</td> <td style="width: 20%;"><input type="checkbox"/> Yes</td> <td style="width: 35%;"><input type="checkbox"/> No</td> </tr> <tr> <td>AIDS, AIDS related complex or infection by HIV</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Willful misuse of any alcohol, narcotic or drug</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table> <p>Please give details if any of the above item(s) is/ are applicable.</p> | | self-inflicted injuries while sane or insane | <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS, AIDS related complex or infection by HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Willful misuse of any alcohol, narcotic or drug | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| self-inflicted injuries while sane or insane | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | |
| AIDS, AIDS related complex or infection by HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | |
| Willful misuse of any alcohol, narcotic or drug | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | |
| <p>17. Other information that would assist us in assessing this claim.</p> | | | | | | | | | | |

Name of Physician: _____ Qualification: _____

Hospital (if applicable): _____ Tel. No: _____ Fax: _____

Signature & Hospital/Physician Chop: _____ Date: _____