

## ATTENDING PHYSICIAN'S STATEMENT CANCER/MAJOR CANCERS

### Part 1 (To be completed by the Insured)

Policy No.	Plan Type	Claim No.
Name of Insured (as shown in NRIC)		NRIC No.
Address		
Name of Next-of-Kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC No.
Address of Next-of-Kin		
<p><b>Authorisation</b> I agree and authorise: (a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by NTUC Income; and (b) NTUC Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer or organisation or person. A photocopy of this form is valid as an original copy.</p>		
_____ Signature/Thumbprint of Insured/Next-of-Kin*		_____ Date (dd/mm/yyyy)

### Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC No.	
<b>A. GENERAL INFORMATION</b>		
1. Are you the Insured's usual doctor? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Over what period do your records extend?		
Start Date (dd/mm/yyyy) _____ / _____ / _____	End Date (dd/mm/yyyy) _____ / _____ / _____	
2. When did the Insured first consult you for this condition? (dd/mm/yyyy) _____ / _____ / _____		
3. When you first saw the Insured, what were the symptoms presented and their duration? Please state date of onset of symptoms.		
Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)
What/Who is the source of this information?		

\* Please delete accordingly.

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4. Did the Insured consult any other doctors for this illness or its symptoms <u>before</u> he/she consulted you? If "Yes", please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of doctor	Name and address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made
<b>B. DETAILS OF DREAD DISEASE</b>			
5. a) What is the diagnosis? Please provide full details of the diagnosis.			
b) Date of diagnosis (dd/mm/yyyy) _____ / _____ / _____			
c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.			
d) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy) _____ / _____ / _____			
6. a) Was a biopsy of the tumour performed? If "Yes", please state the date of biopsy (dd/mm/yyyy) _____ / _____ / _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
b) What was the site or organ involved?			
c) What is the histological diagnosis of the disease (please provide histology of the tumour)?			
d) What is the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TNM Classification, etc.).			
i) Has the cancer spread beyond the layer of cells in which it began?			<input type="checkbox"/> Yes <input type="checkbox"/> No
ii) Was the disease completely localised?			<input type="checkbox"/> Yes <input type="checkbox"/> No
iii) Was there invasion of adjacent tissues?			<input type="checkbox"/> Yes <input type="checkbox"/> No
iv) Were regional lymph nodes involved?			<input type="checkbox"/> Yes <input type="checkbox"/> No
v) Were there distant metastases? If "Yes", please provide full details, including site of any metastases, etc.			<input type="checkbox"/> Yes <input type="checkbox"/> No
e) If the diagnosis is leukaemia, please provide details of actual type.			
f) In the case of a malignant melanoma, please give full details of size, thickness (Breslow classification) and depth of invasion (Clark level).			
i) Is the condition melanoma of less than 1.5mm Breslow thickness or less than Clark Level 3?			<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Please provide full details of all treatment provided (e.g. surgery, chemotherapy, radiotherapy, etc.), including dates and duration of each treatment.				
Type of Treatment	Date of Treatment (dd/mm/yyyy)		Duration of Treatment	
8. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports.				
9. Please provide details of all doctors and clinics/hospitals to which the Insured has been referred to or attended for this condition.				
Name of doctor	Name and Address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made	
<b>C. MEDICAL HISTORY</b>				
10. Has the Insured ever had any malignant, pre-malignant or other related conditions or risk factors? If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information.				<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Please give details of the Insured's medical history which would have increased the risk of Cancer (including nature of illness, date of diagnosis and source of information).				
12. Please give details of the Insured's family history which would have increased the risk of Cancer (including the relationship, nature of illness, date of diagnosis and source of information).				
13. Please give details of the Insured's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.				
14. Please give details of the Insured's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information.				
15. Does the Insured have or ever had any other significant health condition(s)? If "Yes", please provide details.				<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis	Name of doctor	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

**D. OTHERS**

16. Is the condition carcinoma-in-situ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Is the condition pre-malignant or non-invasive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Is the condition Cervical Dysplasia CIN 1, CIN 2, CIN 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Is the condition Hyperkeratoses, basal cell and squamous skin cancers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Is the condition Prostatic cancer described as TNM classification T1 (T1a or T1b) or another equivalent or lesser classification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Is the condition Papillary Carcinoma of the Thyroid of less than 1 cm in diameter?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Is the condition Papillary Carcinoma of the Bladder of less than RAI Stage 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Is the condition Chronic Lymphocytic Leukaemia of less than RAI Stage 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Is the tumour in the presence of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes" please state: a) HIV antibody status _____ b) Date of diagnosis for HIV/AIDS (dd/mm/yyyy) _____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**E. ADDITIONAL INFORMATION**

25. Please provide us with any other additional information that will enable us to assess this claim.

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date (dd/mm/yyyy)

\_\_\_\_\_  
Name and Qualification (printed)

\_\_\_\_\_  
Address & Official Stamp of Clinic/Hospital