

**ATTENDING PHYSICIAN'S STATEMENT
HEART ATTACK/CORONARY ARTERY BYPASS SURGERY/
ANGIOPLASTY AND OTHER INVASIVE TREATMENT FOR CORONARY ARTERY**

Part 1 (To be completed by Insured)

Policy No.	Plan Type	Claim No.
Name of Insured (as shown in NRIC)		NRIC No.
Address of Insured		
Name of Next-of-Kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC No.
Address of Next-of-Kin		
<p>Authorisation I agree and authorise:</p> <p>(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</p> <p>(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.</p> <p>A photocopy of this form is valid as an original copy.</p>		
_____ Signature/Thumbprint of Insured/Next-of-Kin ¹		_____ Date (dd/mm/yyyy)
¹ Please delete accordingly		

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC No.
A. GENERAL INFORMATION	
1. Are you the Insured's usual doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Over what period do your records of the Insured 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?	

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9. What was the left ventricular ejection fraction at initial diagnosis? Please provide date of test and specification of type of test.			
10. Was there left ventricular ejection fraction of less than 50% measured three months or more after the event? If "Yes", please provide date of test, specification of type of test and test results.			<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Please provide details of all investigations/tests performed and enclose copies of all reports, e.g. resting ECGs, exercise stress tests, cardiac enzyme assays, imaging, coronary angiography, echocardiography, myocardial perfusion scans and other relevant hospital reports.			
12. 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
C. DETAILS OF DREAD DISEASE – CORONARY ARTERY BYPASS SURGERY <input type="checkbox"/>			
13. Please describe the full and exact diagnosis of the heart condition leading to surgery.			
14. a) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.			
b) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy): _____ / _____ / _____			
15. Please provide details of the coronary angiogram performed.			
16. Which arteries are involved and what is the degree (%) of narrowing in respect of each artery involved?			
17. a) What type of surgery was performed?			
b) Date of Surgery (dd/mm/yyyy): _____ / _____ / _____			
c) Was it an open-chest (open-heart) surgery?			<input type="checkbox"/> Yes <input type="checkbox"/> No
18. If coronary bypass grafting has been performed, please state the number and sites of graft inserted.			
19. a) Name and address of surgeon who performed the surgery			
b) Name and address of hospital where the surgery was performed			
20. Please provide full details of any other treatment provided.			
21. Please provide details of all investigations/tests performed and attach copies of results of any investigations performed, e.g. resting ECGs, exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.			

22. 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
23. Was the coronary artery condition treated only by angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures? If "Yes", please describe the treatment administered.			<input type="checkbox"/> Yes <input type="checkbox"/> No
D. DETAILS OF DREAD DISEASE – ANGIOPLASTY AND OTHER INVASIVE TREATMENT FOR CORONARY ARTERY <input type="checkbox"/>			
24. Please describe the full and exact details of the diagnosis.			
25. a) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.			
b) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy) : _____ / _____ / _____			
26. Please specify the coronary arteries involved and the percentage of stenosis as shown below:			
	Coronary Artery	Stenosis	Percentage of Stenosis
(i)	Left Main Stem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(ii)	Left Anterior Descending Artery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(iii)	Left Circumflex Artery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(iv)	Right Coronary Artery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27. a) What type of procedure was performed?			
b) Date of Procedure (dd/mm/yyyy): _____ / _____ / _____			
c) Was the procedure medically necessary?			<input type="checkbox"/> Yes <input type="checkbox"/> No
28. a) Name and address of surgeon who performed the procedure			
b) Name and address of hospital where the procedure was performed			
29. Has the Insured undergone a similar procedure before? If "Yes", please state date and place where it was performed.			<input type="checkbox"/> Yes <input type="checkbox"/> No
30. Please provide details of all investigations/tests performed and attach copies of results of any investigations performed, e.g. resting ECGs, exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.			

31. 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

E. MEDICAL HISTORY

32. Has the Insured previously suffered from the above illnesses or any other cardiovascular diseases? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
33. Please give details of the Insured's medical history which would have increased the risk of a Heart Attack or Coronary Artery Disease (including the relationship, nature of illness, date of diagnosis and source of information).	
34. Please give details of the Insured's family history which would have increased the risk of a Heart Attack or Coronary Artery Disease (including the relationship, nature of illness, date of diagnosis and source of information).	
35. 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.	
36. 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.	
37. 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

F. ADDITIONAL INFORMATION

38. 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