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Attending Medical Practitioner's Statement

Part 1 (To be completed by Insured)

Policy number	Plan type	Claim number
Name of insured (as shown in NRIC)		NRIC number
Address of insured		
Name of next-of-kin (if insured is below 21 or deceased)	Relationship to insured	NRIC number
Address of next-of-kin		

Declaration and Authorisation
1. I confirm that I have agreed to the "Personal data use statement" provided in the Medical/Accident/Living/Total & Permanent Disability claim form.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner to release to Income any information as requested by Income; and
   (b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner.

A photocopy of this form is valid as an original copy.

Signature/Thumbprint of insured/next-of-kin[1] _____ Date (dd/mm/yyyy) _____

[1] Please delete accordingly

Heart Attack / Coronary Artery Bypass Surgery / Angioplasty And Other Invasive Treatment For Coronary Artery
Part 2 (To be completed by Doctor)

Name of insured (as shown in NRIC)	NRIC number

A. General information

1. (a) Are you the Insured's usual doctor? ☐ Yes ☐ No

   (b) 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?

4. Did the Insured consult any other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐ No
   If "Yes", please provide details.

Name of doctor	Name and address of clinic / hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

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Please tick the specific medical condition or procedure (heart attack or coronary artery bypass surgery or angioplasty & other invasive treatment for coronary artery) the insured is suffering from, and answer the questions in the approriate sections accordingly:

Heart Attack – Sections B, E & F
Coronary Artery Bypass Surgery – Sections C, E & F
Angioplasty & Other Invasive Treatment For Coronary Artery – Sections D, E & F

B. Details of dread disease – Heart attack ☐

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. Please describe the initial episode.
(a) Date of Heart Attack (dd/mm/yyyy): _____ /_____ /_____

(b) Is the Insured able to return to normal activities? If "Yes", please state when (dd/mm/yyyy): _____ /_____ /_____ If "No", please state the Insured's current physical and mental limitations.	☐ Yes ☐ No
7. Has the patient previously suffered from a heart attack or any related illnesses, e.g., hypertension, angina or other vascular diseases? If "Yes", please provide details.	☐ Yes ☐ No

Diagnosis	Date of Diagnosis (dd/mm/yyyy)	Treatment Given

8. Please confirm the following. If "Yes" to any question, please elaborate with supporting evidence including date of test and test results. (a) Were there any ECG findings indicative of new myocardial infarct? If "Yes", please provide details.	☐ Yes ☐ No
(b) Was there any: i. ST elevation or depression?	☐ Yes ☐ No
i. T wave inversion?	☐ Yes ☐ No
ii. Pathological Q waves?	☐ Yes ☐ No
iii.Left bundle branch block?	☐ Yes ☐ No
(c) Was there a current history of typical chest pain and/or shortness of breath?	☐ Yes ☐ No
(d) Was there death of a portion of the heart muscle? If "Yes", please provide details.	☐ Yes ☐ No
(e) Was there a diagnostic elevation of cardiac enzyme CK-MB? If "Yes", please provide date of test and test results, and attach a copy of the laboratory results: Date & time of test (*before* any cardiac procedure) Test results Date & time of test (*after* any cardiac procedure) Test results	☐ Yes ☐ No

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(f) Was there a diagnostic elevation of Troponin (T or I)? If "Yes", please provide date of test and test results, and attach a copy of the laboratory results: ☐ Yes ☐ No

Date & time of test (*before* any cardiac procedure) Test results (ng/ml)

Date & time of test (*after* any cardiac procedure) Test results (ng/ml)

(g) Was there a diagnostic elevation of any other cardiac enzymes? If "Yes", please provide type of cardiac enzyme(s), date of test and test results, and attach a copy of the laboratory results: ☐ Yes ☐ No

Cardiac Enzyme Date & time of test (*before* any cardiac procedure) Test results

Cardiac Enzyme Date & time of test (*after* any cardiac procedure) Test results

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. ☐ Yes ☐ No

11. Was there imaging evidence of new loss of viable myocardium or new regional wall motion abnormality? If "Yes", please elaborate with supporting evidence of imaging reports and name of attending cardiologist. ☐ Yes ☐ No

C. Details of dread disease – Coronary artery bypass surgery ☐

12. Please describe the full and exact diagnosis of the heart condition leading to surgery.

13. (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): _____ /_____ /_____

14. Please provide details of the coronary angiogram performed.

15. Please specify the coronary arteries involved and the degree (%) of narrowing, and attach a copy of the angiogram report.

Coronary Artery	Stenosis	Percentage of blockage (%)
Left Main Stem	☐ Yes ☐ No	
Left Anterior Descending Artery	☐ Yes ☐ No	
Left Circumflex Artery	☐ Yes ☐ No	
Right Coronary Artery	☐ Yes ☐ No	

(a) Please tick (✓) the type of surgery performed:
- ☐ Open-chest Coronary Artery Bypass Surgery
- ☐ Minimally Invasive Direct Coronary Artery Bypass Surgery

(b) Date of Surgery (dd/mm/yyyy): _____ /_____ /_____

16. Please state the number and sites of graft inserted.

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17. (a) Name and address of surgeon who performed the surgery

(b) Name and address of hospital where the surgery was performed

18. Please provide full details of any other treatment provided.

19. 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. ☐ Yes ☐ No

D. Details of dread disease – Angioplasty and other invasive treatment for coronary artery ☐

20. Please describe the full and exact details of the diagnosis.

21. (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): _____ /_____ /_____

22. Please specify the coronary arteries involved and the degree (%) of narrowing, and attach a copy of the angiogram report.

Coronary Artery	Stenosis	Percentage of blockage
Left Main Stem	☐ Yes ☐ No	
Left Anterior Descending Artery	☐ Yes ☐ No	
Left Circumflex Artery	☐ Yes ☐ No	
Right Coronary Artery	☐ Yes ☐ No	

23. (a) What type of procedure was performed?

(b) Date of Procedure (dd/mm/yyyy): _____ /_____ /_____

(c) Was the procedure medically necessary? ☐ Yes ☐ No

24. (a) Name and address of surgeon who performed the procedure

(b) Name and address of hospital where the procedure was performed

25. Has the Insured undergone a similar procedure before? If "Yes", please state date and place where it was performed. ☐ Yes ☐ No

E. Medical history

26. Has the insured previously had any cardiac investigation done (e.g. ECG, echocardiogram, CT scan etc.)? ☐ Yes ☐ No
If "Yes", please provide details:
(a) Type, results and date of cardiac investigation done:

(b) Reason(s) for the investigation:

(c) Name of doctor and address of hospital/clinic:

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27. Has the Insured previously suffered from any risk factors or related illnesses, e.g. hypertension, diabetes, angina or other cardiovascular diseases?
If "Yes", please provide details.

☐ Yes ☐ No

28. 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).

29. 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).

30. 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.

31. Please give details of the Insured's habits in relation to alcohol consumption, including the type of alcohol, amount of alcohol consumption per day and source of this information.

32. Does the Insured have or ever had any other significant health condition(s)?
If "Yes", please provide details.

☐ Yes ☐ No

Diagnosis	Name of doctor	Name and address of clinic / hospital	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

F. Additional information

33. Please provide details of all investigations/test 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.

34. 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

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

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Signature of doctor	Date (dd/mm/yyyy)
Name and qualification (printed)	Address & official stamp of clinic/Hospital