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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

Cancer / Major Cancers
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?

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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

B. Details of dread disease

5. (a) What is the histological diagnosis of the disease?

(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? ☐ Yes ☐ No
   If "Yes", please state the date of biopsy (dd/mm/yyyy): _____ /_____ /_____
   If "No", please state why and how the diagnosis was confirmed.

(b) What was the site or organ involved?

(c) 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? ☐ Yes ☐ No

ii. Was the disease completely localised? ☐ Yes ☐ No

iii. Was there invasion of adjacent tissues? ☐ Yes ☐ No

iv. Were regional lymph nodes involved? ☐ Yes ☐ No

v. Were there distant metastases? ☐ Yes ☐ No
   If "Yes", please provide full details, including site of any metastases, etc.

7. Is the condition carcinoma-in-situ? ☐ Yes ☐ No

8. Is the condition pre-malignant or non-invasive? ☐ Yes ☐ No

9. Is the condition having borderline malignancy or is suspicious of malignancy only? ☐ Yes ☐ No

10. Is the condition Cervical Dysplasia CIN 1, CIN 2, CIN 3 (severe dysplasia without Carcinoma-in-situ)? ☐ Yes ☐ No

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11. Is the condition Carcinoma-in-situ of the Biliary system?	☐ Yes ☐ No
12. Is the condition Hyperkeratoses, basal cell and squamous skin cancers?	☐ Yes ☐ No
13. (a) Is the condition Bladder Cancer described as TNM classification T1N0M0 or below?	☐ Yes ☐ No
(b) Is the condition Papillary Micro-carcinoma of the Bladder?	☐ Yes ☐ No
14. Is the condition Prostate cancer described as TNM classification T1N0M0, T1 or another equivalent or lesser classification? If yes, please circle: T1a / T1b / T1c	☐ Yes ☐ No
15. (a) Is the condition Thyroid Cancer described as TNM classification T1N0M0 or below? If "Yes", please state the size in diameter _____ cm	☐ Yes ☐ No
(b) Is the condition Papillary Micro-carcinoma of the Thyroid? If "Yes", please state the size in diameter _____ cm	☐ Yes ☐ No

16. If the diagnosis is leukaemia, please state:

(a) Type of leukaemia _____

(b) RAI staging _____

17. If the diagnosis is malignant melanoma, please give full details below:

(a) Size, Thickness (Breslow classification) (mm) _____

(b) Depth of invasion (Clark level) _____

(c) Has the condition caused invasion beyond the epidermis?	☐ Yes ☐ No

18. If the diagnosis is Gastro-Intestinal Stroma Tumour (GIST), please state:

(a) Tumour classification (TNM classification) _____

(b) Mitotic count (in HPFs) _____

19. 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.

C. Details of treatment

20. (a) 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

(b) Has active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details why this view/course of action is taken.	☐ Yes ☐ No
(c) i. Was radical surgery (total and complete removal of the affected organ) done? If "Yes", please state the name of the surgery, surgical code/table. Date surgery was performed (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No
ii. For mastectomy cases, was reconstructive surgery done or recommended? If "Yes", please state date surgery was performed (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No

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21. Is the Insured still on follow-up at your clinic? ☐ Yes ☐ No

If "Yes", please provide state date of next appointment (dd/mm/yyyy) _____ /_____ /_____

If "No", please provide date of discharge (dd/mm/yyyy) _____ /_____ /_____

22. (a) Is the Insured terminally ill, i.e. death is expected within 12 months? ☐ Yes ☐ No

If "Yes", please provide details on the basis of your evaluation.

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) _____ /_____ /_____

(b) Is the Insured referred to hospice care? ☐ Yes ☐ No

If "Yes", please state:

Name of hospice _____

☐ Inpatient – Date of admission (dd/mm/yyyy) _____ /_____ /_____

☐ Day care – Start date (dd/mm/yyyy) _____ /_____ /_____

23. 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

D. Additional information

24. Has the Insured ever had any malignant, pre-malignant or other related conditions or risk factors? ☐ Yes ☐ No
If "Yes", please provide details, including diagnosis, date of diagnosis, dates of consultation, name and address of doctor/ clinic and source of information.

25. 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).

26. 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).

27. 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.

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

29. Is the tumour or cancer in any way caused directly or indirectly by alcohol or drug abuse? ☐ Yes ☐ No

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30. Is the tumour in the presence of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

If "Yes" please state:

(a) HIV antibody status _____

(b) Date of diagnosis for HIV/AIDS (dd/mm/yyyy) _____ /_____ /_____

31. Does Insured have or ever had any other significant health condition(s)? ☐ Yes ☐ No

If "Yes", please provide details.

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

32. 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