



**Critical Illness Claim - Doctor's Statement**  
**Major Cancer / Carcinoma in-situ / Early Cancers / Borderline Malignant Tumour**  
**/ Benign Tumour (suspected malignancy) requiring surgical excision**

**DOCTOR'S STATEMENT** (to be completed by the attending doctor at claimant's expense)

Please tick (✓) the appropriate box for medical condition(s) applicable	Sections to be completed
<input type="checkbox"/> Cancer (including Major Cancer, Carcinoma in-situ, Early Cancers)	Sections A, B, C, E and F
<input type="checkbox"/> Borderline Malignant Tumour	Sections A, B, C, E and F
<input type="checkbox"/> Benign Tumour (suspected malignancy) requiring surgical excision	Sections A, B, C, D, E and F

<b>A) Patient's Particulars</b>											
Name of Patient	Gender										
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)										
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<b>B) Patient's Medical Records</b>											
1) Please indicate the period that is documented in the hospital/clinic's record:											
(i) Date of <b>First</b> Consultation (ddmmyyyy)	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
(ii) Date of <b>Last</b> Consultation (ddmmyyyy)	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
(iii) Number of consultations during the above period:											
(iv) Name of hospital/clinic and reason(s) for consultations (with dates):											
2) Are you the patient's usual medical doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If "Yes", since when? (ddmmyyyy)	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
If "No", please provide name and address of the patient's regular doctor.											
3) Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If "Yes", please provide:											
(i) Date referred (ddmmyyyy)	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
(ii) Reason for referral:											
(iii) Name and address of referring doctor:											
If "No", please indicate how the patient came to consult at your hospital/clinic? (e.g. A&E.)											

4) Have you referred the patient to any other doctor?  Yes  No  
 If "Yes", please advise:  
 (i) Date referred (ddmmyyyy) 

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 (ii) Reason for referral:  
 (iii) Name and address of doctor referred to:

5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc.)  Yes  No  
 If "Yes", please advise:  

<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>
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6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5) above.

7) What is your source of the above information?

8) Please give details of the patient's **smoking** habits, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.  

<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>
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9) Please give details of the patient's **alcohol consumption** habits, including the amount of the alcohol consumption, frequency, and the source of this information.  

<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency</u> (per week / month, etc.)	<u>Source of information</u>
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**C) Details of Illness**

1) Please provide details of **condition** (please tick where as applicable):  
 Major Cancers / Carcinoma in-situ / Early Cancer       Benign Tumour (suspected malignancy) requiring surgical excision  
 Borderline Malignant Tumour

(i) Date the patient **First** consulted you for the condition (ddmmyyyy): 

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(ii) Details of symptom(s) presented at **First** consultation:

(iii) Date of onset of these symptoms (ddmmyyyy): 

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(iv) What is/are the underlying cause(s) of the symptoms?

(v) <b>Final</b> Diagnosis of the condition:		
(vi) ICD-10 Code:		
(vii) Date of <b>First</b> diagnosis (ddmmyyy):		
(viii) Date the patient <b>First</b> became aware of the illness/condition (ddmmyyy):		
2) Name and address of the doctor who <b>First</b> diagnosed the patient with the condition:		
3) Please indicate the organ(s) involved in the patient's tumour or primary cancer:		
<input type="checkbox"/> Eye	What component(s) of the eye is/are involved?	
<input type="checkbox"/> Nasopharynx		
<input type="checkbox"/> Skin		
<input type="checkbox"/> Nerve(s) in cranium or spine	What nerve(s) is/are involved?	
<input type="checkbox"/> Heart	What heart chamber(s) is/are involved?	
<input type="checkbox"/> Pericardium		
<input type="checkbox"/> Lung	<input type="checkbox"/> Left lung	<input type="checkbox"/> Right lung
<input type="checkbox"/> Liver	<input type="checkbox"/> Left Liver	<input type="checkbox"/> Right Liver
<input type="checkbox"/> Colon	What segment(s) of the colon is/are involved?	
<input type="checkbox"/> Rectum		
<input type="checkbox"/> Breast	<input type="checkbox"/> Left breast	<input type="checkbox"/> Right breast
<input type="checkbox"/> Uterus	<input type="checkbox"/> Endometrial polyp	<input type="checkbox"/> Other than endometrial polyp
<input type="checkbox"/> Cervix		
<input type="checkbox"/> Prostate		
<input type="checkbox"/> Thyroid		
<input type="checkbox"/> Other organs (please specify the organs involved)		
4) Was a biopsy performed to investigate the tumour?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please advise:		
Date of biopsy (ddmmyyy)		
Detail of the biopsy:		
If "No", please advise on the clinical basis for establishing the histological nature of the tumour.		

<p>5) Please provide full details and results of all <b>investigations</b> (with dates) performed for the diagnosis. Also, please <b>attach</b> a copy of all the relevant test reports.</p>
<p>6) What is the staging of the cancer or tumour?</p> <p>(i) TNM Stage: T_____ N_____ M_____</p> <p>(ii) Other stage (if applicable):</p> <p>a) Provide <b>above findings</b> based on the histopathology report:</p> <p>b) Please attach a copy of the histopathology report which confirmed the findings and diagnosis.</p>
<p>7) Is the tumour classified as</p> <p>(i) uncontrolled growth of malignant cells with invasion? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>(ii) destruction of normal tissue? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes",</p> <p>a) Provide <b>above findings</b> based on the histopathology report:</p> <p>b) Please attach a copy of the histopathology report which confirmed the findings and diagnosis.</p>
<p>8) Is the tumour classified as morphological code 8000/1 according to ICD-0-3? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "No", please state the morphological code of the tumour according to ICD-0-3.</p>
<p>9) Is there evidence of metastasis to the lymph node(s)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes", please provide the region(s) of lymph node(s) involved.</p>
<p>10) Is there evidence of metastasis to distant organ(s)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes", please provide the distant organ(s) involved in the cancer metastasis.</p>

11) Did the patient undergo any surgery?

Yes  No

If "Yes", please advise:

(i) Date of surgery (ddmmyyy):

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(ii) Nature or type of the surgery performed (e.g. mastectomy, hysterectomy, prostatectomy, gastrectomy, etc.)  
Please provide a copy of the surgical report and histopathology report.

a) If the patient undergone mastectomy, was there surgical removal of at least three quadrants of the tissue of a breast?

Yes  No

If "Yes", please provide findings based on the surgery report:

b) If the patient undergone hysterectomy, was there surgical removal of the uterus (at least the corpus and cervix or corpus only)?

Yes  No

If "Yes", please provide findings based on the surgery report:

(iii) Specify whether there was full or partial resection of the tumour:

Full Resection  Partial Resection  Others, please specify:

(iv) The exact site(s) and organ(s) that was/were surgically removed.

(v) Was the procedure considered as open or closed biopsies, needle aspiration biopsy or cytology, aspiration?

Yes  No

Please specify procedure:

12) Did the patient undergo any other mode of treatment? (e.g. chemotherapy, radiotherapy, recurrent blood transfusions, bone marrow transplant, haematopoietic stem cell transplant, other major interventionist treatment, etc.).  Yes  No

If "Yes", please advise:

<u>Date of Treatment</u> (ddmmyyyy)	<u>Type of Treatment</u>	<u>Duration of Treatment</u>	<u>Patient's Response to the Treatment</u>
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13) Is the tumour histologically described as:

- (i) invasive cancer including microinvasion cancer within primary tissue?  Yes  No
  - (ii) pre-malignant?  Yes  No
  - (iii) non-invasive?  Yes  No
  - (iv) carcinoma-in-situ (Tis)?  Yes  No
  - (v) carcinoma-in-situ (Ta)?  Yes  No
  - (vi) having borderline malignancy?  Yes  No
  - (vii) having any degree of malignant potential?  Yes  No
  - (viii) having suspicious malignancy?  Yes  No
  - (ix) neoplasm of uncertain or unknown behaviour?  Yes  No
  - (x) benign tumour?  Yes  No
  - (xi) All grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL), Prostatic Intraepithelial Neoplasia (PIN), Vulvar Intraepithelial Neoplasia (VIN) and Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, CIN II and CIN III (severe dysplasia without carcinoma in-situ).  Yes  No
- If "Yes" to (xi), please state:

Exact classification: \_\_\_\_\_

14) For Skin Cancer, is the tumour histologically described as:

- (i) hyperkeratosis, bascal cell or squamous skin cancers?  Yes  No
- (ii) a melanoma with a Breslow thickness of less than 1.5mm or a Clark level of less than 3?  Yes  No
- (iii) a melanoma without evidence of invasion beyond the epidermis?  Yes  No
- (iv) a non-melanoma skin carcinoma without evidence of metastases to lymph nodes or beyond?  Yes  No
- (v) a skin confined primary cutaneous lymphoma without evidence of metastases to lymph nodes or beyond?  Yes  No
- (vi) a dermatofibrosarcoma protuberans without evidence of metastases to lymph nodes or beyond?  Yes  No

15) For Gastro-Intestinal Stromal tumours (GIST), please advise:	
(i) Is the tumour histologically described as T1N0M0 (TNM classification) or below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) Is the tumour histologically described as Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual, or below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iii) Is the mitotic count of less than or equal to 5/50 HPFs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No" to (ii), what was mitotic count in HPFs?	
16) For Leukaemia, please advise:	
(i) Is the patient diagnosed of Chronic Lymphocytic Leukemia less than RAI Stage 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No" to (i), please state:	
Type of leukaemia: _____	
RAI Staging: _____	
17) For Bone Marrow condition, please advise whether the condition:	
(i) is malignant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) does not require recurrent blood transfusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iii) does not require chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iv) does not require targeted cancer therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(v) does not require bone marrow transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(vi) does not require hematopoietic stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(vii) does not require other major interventionist treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18) For Urinary Bladder Cancer, is the tumour histologically described as:	
(i) a papillary microcarcinoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) T1N0M0 (TNM classification) or below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19) For Thyroid Cancer, is the tumour histologically described as:	
(i) a papillary microcarcinoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) T1N0M0 (TNM classification) or below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please state the size of the tumour in diameter: _____ Centimetres (CM)	
20) For Prostate Cancer, is the tumour histologically described as:	
(i) T1N0M0 (TNM classification) or below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to (i), please state the staging ie T1aN0M0 / T1bN0M0 / T1cN0M0: _____	
21) For Neuroendocrine Cancer, is the tumour histologically described as:	
(i) T1N0M0 (TNM classification) or below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) a pituitary neuroendocrine tumour (PitNET)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

22) (i) Has the current cancer persisted for more than 2 years since the **First** diagnosis?  Yes  No

If "Yes", please provide:

a) Details on the previous cancer and copy of the histopathological report(s).

Date of <b>First</b> Diagnosis of previous cancer (ddmmyyyy)	Details of histopathological report(s) of previous cancer:

b) Is there a Histopathological report to confirm that the current cancer has persisted for more than 2 years?

Yes  No

If "Yes", please provide details on the histopathological report(s) and a copy of the histopathological report(s).

Date of histopathological report(s) (ddmmyyyy)	Details of the histopathological report(s):

(ii) Is the current cancer a relapse of the same cancer that occurred previously?

Yes  No

If "Yes", please provide details on the previous cancer and copy of the histopathological report(s).

Date of <b>First</b> Diagnosis of previous cancer (ddmmyyyy)	Details of histopathological report(s) of previous cancer	Duration of remission before the current relapse										
		Was the previous cancer in remission before the current relapse? <input type="checkbox"/> Yes <input type="checkbox"/> No  If "Yes", please provide the date (ddmmyyyy) in which the patient is deemed to be in remission prior to the relapse: <table border="1" style="width: 100%; height: 20px;"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										

(iii) Did the patient undergo any preventive therapy? (e.g. preventive cancer therapy, etc)

Yes  No

If "Yes", please advise:

Date of Treatment  
(ddmmyyyy)

Type of Treatment

Duration of Treatment

Patient's Response to the Treatment

23) What is the prognosis of the patient's condition?

**D) Benign Tumour (Suspected Malignancy) Requiring Surgical Excision Only**

1) Was the tumour considered a suspicious malignancy based on a full and appropriate investigation (before operation)?  Yes  No  
If "Yes", please elaborate further on the finding(s) of suspicious malignancy.

2) Prior to any surgical excision, was the tumour considered to have a suspicion of malignancy based on full and appropriate investigations?  Yes  No

If "Yes", please advise:

(i) Exact Diagnosis of the condition **prior** to any surgical excision

(ii) ICD-10 Code

(iii) Details on the finding(s) which led to suspicion of malignancy and attach a copy of all relevant test reports which confirmed the findings.

3) Was the tumour  
(i) completely removed due to a suspicion of malignancy?  Yes  No  
(ii) partially removed due to a suspicion of malignancy?  Yes  No

If "Yes", please advise:

a) Date of surgery (ddmmyyyy)

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b) Nature or type of the surgery performed

Please provide a copy of histopathological examination after surgical excision with confirmation of non-cancerous tumour.

If "No", please state the reason(s) for the full resection of the tumour.

4) Was there evidence of a non-cancerous benign tumour confirmed by histopathological examination after the surgical excision?  Yes  No

If "Yes", please attach a copy of the histopathology report after the surgical excision which confirmed the findings and diagnosis.

5) Please confirm whether the patient underwent surgery for:

(i) Ovarian cyst(s) including but not limited to simple cysts, endometrial cysts (endometriomas) of the ovary  Yes  No

If "Yes", please state the condition:

6) Please confirm whether the patient underwent surgery for removal of:

(i) Gallbladder  Yes  No

(ii) Gallstone(s)  Yes  No

(iii) Kidney Stone(s)  Yes  No

(iv) Benign hormone secreting tumour of the adrenal glands  Yes  No

7) Please confirm whether the patient underwent surgery for tumour which was considered as

(i) High grade dysplasia  Yes  No

(ii) Lipoma  Yes  No

(iii) Haemangioma  Yes  No

(iv) Non-Solid Tumours including simple cysts  Yes  No

Note: "Solid Tumour" means an abnormal mass of tissue, which is not cyst and generally does not contain liquid.

**E) Other Information**

1) Was the patient admitted at the hospital for treatment of the diagnosis?

Yes  No

If "Yes", please advise:

<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		

2) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the diagnosis?

Yes  No

If "Yes", please advise:

<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		

3) Is the tumour or cancer directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection?  Yes  No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (ddmmyyyy)

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Date the patient **First** became aware of the condition (ddmmyyyy)

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(ii) Wilful misuse of alcohol?  Yes  No

(iii) Wilful misuse of drugs?  Yes  No

(iv) Congenital anomaly or defect?  Yes  No

If "Yes", please provide full details including reasons for the result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and hospital/clinic where the patient was **First** diagnosed with HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

Please provide a copy of the relevant test result(s).

4) Is there anything in the patient's **lifestyle** or **personal medical history** which may have increased the risk of the condition?  Yes  No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis

Date of diagnosis

Name of doctor & address of hospital/clinic

5) Is there anything in the patient's **family history** which may have increased the risk of the condition?  Yes  No

If "Yes", please advise:

Relationship with patient

Nature of condition

Age of onset

Source of information

6) Have active treatment and therapy now been rejected in favour of relief of symptoms?  Yes  No  
 If "Yes", please provide full details and explain the reason for this course of action.

7) Based on the **Last** consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:

(i) Six (6) months?  Yes  No

(ii) Twelve (12) months?  Yes  No

If "Yes" to (i) and/or (ii), please advise:

a) Medical treatment(s) that had been provided to the patient

b) Prognosis after undergoing the mentioned medical treatment(s)

c) Any other details on the basis of your evaluation.

8) Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation(s).

9) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitation(s), including the degree of cognitive and/or intellectual impairment.

10) (i) Is the patient mentally incapacitated?  Yes  No

(ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money?  Yes  No

11) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **condition or any other possible related diseases**?  Yes  No

If "Yes", please advise:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First &amp; Last consultation</u>	<u>Reasons for consultation</u>

12) Is the patient still on follow-up at your hospital/clinic?  Yes  No

If "Yes", please state date of next appointment (ddmmyyyy) 

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If "No", please state date of discharge (ddmmyyyy), if any. 

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13) Please provide us with any other additional information that may assist the Company in assessing this claim.

Please enclose copies of all investigation reports including specialist, hospital and laboratory reports. Where applicable, please include the following:

- (i) Biopsy reports, cytology reports, histopathology reports
- (ii) Bone marrow biopsy reports
- (iii) Computerised tomography scan (CT scan)
- (iv) Haematology reports
- (v) Magnetic resonance imaging (MRI), other imaging studies
- (vi) X-Ray
- (vii) Operation reports, surgical reports ie Mastectomy reports, hysterectomy reports
- (viii) Referral letters (if any)
- (ix) Any other investigation reports

**F) Declaration**

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor

Address & Official Stamp of Doctor

Name of Doctor

Date (ddmmyyyy)