



Policy Number

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DISABILITY/ACCIDENT/ HOSPITALISATION CLAIM FORM II

Important note:

Your patient is insured with us against the occurrence of certain contingent events associated with his or her health history. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement. [All costs associated with the claim form to be borne by the patient]

TYPE OF CLAIM BENEFIT

<input type="checkbox"/> Accident Benefit (ECARE/CARE/AB) (Please complete: Section 1, 2, 3, 5 & 7)	<input type="checkbox"/> Disability Income Benefit (DI) (Please complete: Section 1, 2, 3, 5, 6 & 7)	<input type="checkbox"/> Hospital Benefit (Please complete: Section 1, 2, 3, 4, 6 & 7)	<input type="checkbox"/> Waiver of Premium for Disability(WP) Benefit (Please complete: Section 1, 2, 3, 5, 6 & 7)	<input type="checkbox"/> Cancer Treatment (Please complete: Section 1, 2, 3, 4, 6 & 7)
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1. PATIENT'S INFORMATION

Name of patient (Insured)	Macau ID/ Passport No.	
Did the patient have any of the following habits? If yes, please provide the duration and consumption details		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Smoking <input type="checkbox"/> Drugs taking <input type="checkbox"/> Drinking Duration _____ Consumption Per Day _____

2. ABOUT THE CURRENT SICKNESS/ILLNESS

Date of first consultation for this condition	dd ____ mm ____ yyyy _____	Name of the Doctor	
Symptom(s)/ complaint(s) presented during the first consultation		How long had the patient been experiencing these symptoms before the first consultation	
Diagnosis (Provide diagnostic test results confirming the diagnosis)		ICD 10 Codes	
Date of accident	dd ____ mm ____ yyyy _____	Cause of Injury	
Nature, Severity of Injury and body parts injured			

CHK3MEDIC2

MLC131-2511

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Any visible wound? If yes, please tick the appropriate box below and provide details		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bruise	Details:	
<input type="checkbox"/> Laceration / abrasion / wound / bleeding / fractures	Details:	
<input type="checkbox"/> Others, please specify _____	Details:	
Please check the box <input type="checkbox"/> if this Disability may be related to any of the following and provide details as required		
Self-inflicted condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify
Under influence of alcohol and other psychoactive substances	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Involvement in high risk activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AIDS and/or other sexually transmitted diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychological condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and address of doctor who has referred this patient to you for this condition		
Name of the doctor	Corresponding Address	

3. ABOUT THE HOSPITALISATION

Name of hospital			
Date of admission	dd ____ mm ____ yyyy _____	Date of discharge	dd ____ mm ____ yyyy _____
Diagnosis at the time of discharge			
Any Operation/Surgery performed? If yes, provide date of operation	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of operation: dd ____ mm ____ yyyy _____		
Name of surgical procedures			
Any treatment other than Operation/ Surgery performed? If yes, please provide name and date of such treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Treatment Name	Date	dd ____ mm ____ yyyy _____
Whether above operation/surgery/ treatment can be managed on out-patient basis? If yes, please specify the reason(s) for hospitalisation.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the hospitalization associated with treatment, procedure, supplies of experimental or investigative nature?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Brief discharge summary (including investigation tests and results, procedures, treatment, operations, result of such treatment, and/or any complications and follow up plans)			
Did the patient take any home leave during the hospital confinement? If yes, please specify the reason and the period of home leave	<input type="checkbox"/> Yes <input type="checkbox"/> No		

4. ABOUT THE CANCER TREATMENTDid the patient suffer from any tumour, malignant or benign, including pre-cancerous conditions? Yes No

If yes, please state details

Site and organ involved	Lymph node involved

Was biopsy done for the patient? If yes, please provide date and result Yes No

Date	Biopsy result	Other diagnostic/investigation test result
dd ____ mm ____ yyyy _____		
Type of treatment administered	<input type="checkbox"/> Surgical	<input type="checkbox"/> Hormonal Therapy
	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Target Therapy
	<input type="checkbox"/> Others _____	Date dd ____ mm ____ yyyy _____

Please provide details of the treatment including drug name, dosage, frequency, duration of treatment, all other types of treatment and any complications

Has the cancer/tumour been completely removed/eradicated?

Completion Date of all treatments:

dd ____ mm ____ yyyy _____

5. ABOUT THE DISABILITY

Specify all physical or mental impairment - impact, severity and duration as a result of this disability (Provide documentation supporting the degree of disability)	
Provide the prognosis for each of the above (if any)	
Patient's occupation and exact nature of occupational duties	
Please state period in which patient is not able to perform some of his job duties	From _____ To _____ dd/mm/yyyy dd/mm/yyyy
Please state period in which patient is not able to perform all of his job duties	From _____ To _____ dd/mm/yyyy dd/mm/yyyy
Please tick against the box that most accurately describes the Policyholder's/Applicant's ability.	Date the disability started dd ____ mm ____ yyyy _____
Washing or bathing - Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Some help or supervision is needed (e.g. To wash the back, hair) <input type="checkbox"/> Needs someone to help most of the times <input type="checkbox"/> Not able to do at all (needs to be washed or bathed entirely by caregiver)
Dressing - Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances	<input type="checkbox"/> No help is needed <input type="checkbox"/> Some help or supervision is needed (e.g. To button clothes, to put on trousers) <input type="checkbox"/> Needs someone to help most of the times <input type="checkbox"/> Not able to do at all (needs to be dressed entirely by caregiver)
Feeding - Ability to feed oneself food after it has been prepared and made available.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Some help or supervision is needed (e.g. To scoop food, to put food into mouth) <input type="checkbox"/> Needs someone to help most of the times <input type="checkbox"/> Not able to do at all (needs caregiver to feed entirely or is tube-fed)

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Toileting - Ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Some help or supervision is needed (e.g. To get on or off the toilet) <input type="checkbox"/> Needs someone to help most of the times <input type="checkbox"/> Not able to do at all (needs to be placed on the toilet and cleaned by caregiver)
Transferring - Ability to move from a lying position on the bed to an upright chair or wheelchair, and vice versa.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Some help or supervision is needed (e.g. To get on or off the chair/bed) <input type="checkbox"/> Needs someone to help most of the time <input type="checkbox"/> Not able to do at all (needs to be placed on the chair/bed by caregiver)
Mobility - Ability to move indoors from room to room on level surfaces.	<input type="checkbox"/> No help is needed <input type="checkbox"/> Some help or supervision is needed <input type="checkbox"/> Needs someone to help most of the time <input type="checkbox"/> Not able to do at all

6. ABOUT HEALTH HISTORY

Has the patient previously suffered from related conditions of this illness? If yes, please provide the dates of consultation, details of conditions and diagnosis				<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of doctor Consultation or Hospital admission	Name of doctor or hospital	Complaints and Symptoms	Diagnosis	Treatments given (please state name of surgical procedure if performed or to be performed)
dd ____ mm ____ yyyy _____				
dd ____ mm ____ yyyy _____				
Have the biological parents, siblings or children of the patient been diagnosed prior to age 60 with any of the following? If Yes, please complete the table below with exact nature of the illness e.g. breast cancer, colon cancer or heart attack etc.				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Alzheimer’s Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Other Inherited Disease or Disorder				
Relative	Diagnosis/Condition		Onset Age	

7. DECLARATION AND AGREEMENT

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his/her condition. I declare and agree to make the declaration on this claim form.

Name of Physician	Contact tel. no. and mailing address
Qualification	Specialty
Signature of Physician	Signature Date
	dd ____ mm ____ yyyy _____