



Policy Number

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CRITICAL ILLNESS 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]

1. PATIENT'S INFORMATION

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

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	
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			
Transferred to Intensive Care Unit (ICU)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Duration	From dd ___ mm ___ yyyy _____ to dd ___ mm ___ yyyy _____	
	Any invasive life support received? (i.e. mechanical ventilation through tracheal intubation, LVAD, ECMO)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	The use of invasive life support for one hundred and twenty (120) or more consecutive hours	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Any Operation/Surgery performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Operation/ Surgery Name		Date dd ____ mm ____ yyyy _____
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 _____
Brief discharge summary (including investigation tests and results, procedures, treatment, operations, result of such treatment, and/or any complications and follow up plans)			

4. ABOUT THE DISABILITY

Date of accident	dd ____ mm ____ yyyy _____	Cause of Injury	
Please check the box <input checked="" type="checkbox"/> if this Disability may be related to any of the following and provide details as required			
1) Self-inflicted condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify	
2) Under influence of alcohol and other psychoactive substances	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3) Involvement in high risk activities	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4) AIDS and/or other sexually transmitted diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5) Occupation	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6) Psychological condition	<input type="checkbox"/> Yes <input type="checkbox"/> No		

5. ACTIVITIES OF DAILY LIVING

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)	
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 below		<input type="checkbox"/> Yes <input type="checkbox"/> No	
According to your record, did the patient have the following past medical history? If yes, please complete the table below and provide the dates of consultation, details of condition and diagnosis		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Long term medication <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Kidney disease <input type="checkbox"/> Others, please specify details _____			
Date of doctor Consultation or Hospital admission	Name of doctor or hospital	Final 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	
Doctor/Clinic/Hospital Name			

7. SPECIFIC INFORMATION

Note: If the patient suffered any of the below disease, please fill in the details according to the indicated section

- Cancer/Tumour Related Disease → Section A
- Heart Attack → Section B
- Coronary Artery Disease → Section C
- Aorta Disease → Section D
- Stroke → Section E
- Dementia → Section F

Note: For other diseases, please skip the above sections and go straight to Section G

<input type="checkbox"/> A. CANCER/TUMOUR RELATED DISEASE		
Did the patient suffer from any tumour, malignant or benign, including pre-cancerous conditions? If yes, please state details		<input type="checkbox"/> Yes <input type="checkbox"/> No
Site and organ involved	Lymph node involved	
Was biopsy done for the patient? If yes, please provide date and result		<input type="checkbox"/> Yes <input type="checkbox"/> No
Date	Biopsy result	Other diagnostic/investigation test result
dd ___ mm ___ yyyy _____		
dd ___ mm ___ yyyy _____		

What is the Surgical-Pathological cancer staging for this patient? What was the cancer staging system used?			
What is tumour grading?			
Type of treatment administered	<input type="checkbox"/> Surgical	<input type="checkbox"/> Hormonal Therapy	Date
	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Target Therapy	dd ___ mm ___ yyyy _____
<input type="checkbox"/> Others _____			
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 _____
Is there any distant metastasis? What are the body parts involved?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If the diagnosis is Leukaemia, is it Chronic Lymphatic Leukaemia? If yes, please answer below			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please confirm the Rai stage			
If the diagnosis is skin cancer, is it malignant melanoma?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the patient suffer from brain tumour? If yes, please answer below			<input type="checkbox"/> Yes <input type="checkbox"/> No
Site of brain involved	In pituitary gland	In spinal cord	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the tumour in the form of cyst, granulomas, haematomas, and other malformations in or of the blood vessels of the brain? If yes, please provide details			<input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> B. HEART ATTACK			
Did the patient suffer from any chest pain and chest discomfort? If yes, please state the date and symptoms			<input type="checkbox"/> Yes <input type="checkbox"/> No
First Symptom(s) date		Symptoms	
dd ___ mm ___ yyyy _____			
Was there any Electrocardiography (ECG) or other imaging studies done for the patient? If yes, please state the dates, results and provide copies of all available test reports			<input type="checkbox"/> Yes <input type="checkbox"/> No
Date	Type of tests	Results	
dd ___ mm ___ yyyy _____			
dd ___ mm ___ yyyy _____			

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Was there any biochemical markers of myocardial necrosis tests inclusive of CKMB or Cardiac Troponin T or I done for the patient? If yes, please state the dates, results and provide copies of all available test reports		<input type="checkbox"/> Yes <input type="checkbox"/> No
Date	Type of tests	Results
dd ___ mm ___ yyyy _____		
dd ___ mm ___ yyyy _____		

C. CORONARY ARTERY DISEASE

Did the patient suffer from any disorder/problem in any coronary artery? If yes, state the severity (percentage of blockage) and which coronary arteries are involved. <i>Please state the dates, results and provide copies of all available test reports.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Percentage of narrowing or blockage	Coronary arteries involved	Type of treatment performed	Date
			dd ___ mm ___ yyyy _____
			dd ___ mm ___ yyyy _____
			dd ___ mm ___ yyyy _____

D. AORTA DISEASE

Did the patient suffer from any diseases involving the aorta (such as narrowing, blockage, dissection or aneurysm of the thoracic or abdominal aorta)? If yes, please provide details in the following. <i>Please state the dates, results and provide copies of all available test reports</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Final diagnosis	Type of surgery/treatment done	Date
		dd ___ mm ___ yyyy _____

E. STROKE

Did the patient suffer from stroke? If yes, please provide details in the following	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Date	Signs and symptoms	Duration of signs and symptoms
dd ___ mm ___ yyyy _____		

Was there any diagnostic testing done? Please provide details and copies of any studies	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Test results	Date
	dd ___ mm ___ yyyy _____

Is there any evidence of permanent neurological damage? If yes, please provide details in the following	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Type of neurological damage	Permanent	State the duration of this damage
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> F. Dementia	
Did the patient suffer from dementias? If yes, please provide details in the following	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Mini Mental State Examination (MMSE) done for the patient? If yes, please provide date and score	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Mini Mental State Examination Dates	Total score ___/30
dd ___ mm ___ yyyy _____	
Last Mini Mental State Examination Dates	Total score ___/30
dd ___ mm ___ yyyy _____	
Was it related to non-organic brain disorders such as neurosis and psychiatric illnesses/drug or alcohol related organic brain disorder, if yes, please provide details below	<input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> G. OTHERS			
For diagnosis which is not listed in questions (A) to (F) above, please provide details in the following box			
Date	Nature	Signs and symptoms	Duration of signs and symptoms
dd ___ mm ___ yyyy _____			
Was there any diagnostic testing done? Please provide details and copies of any studies			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name and findings of the diagnostic test			
Date of first diagnosis	dd ___ mm ___ yyyy _____		
Type of surgery treatment		Date of surgery treatment	dd ___ mm ___ yyyy _____
Type of non-surgery treatment		Date of non-surgery treatment	dd ___ mm ___ yyyy _____
Is there any evidence of permanent neurological damage? If yes, please provide details below			

8. 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	Mobile no. and mailing address
Qualification	Specialty
Signature of Physician	Signature Date
	dd ___ mm ___ yyyy _____