AIA SINGAPORE
CRITICAL ILLNESS CLAIM

SUBMISSION PROCEDURES

AIA Singapore does not admit liability by the mere issue of this form.

IMPORTANT NOTES FOR CLAIMANT

When making a claim, please take note of the following:

- Claim Form Part I is to be completed by yourself.
- Authorization & Declaration Section of Claim Form Part I is duly signed/ thumbprint affixed by yourself.
- Claim Form Part II is completed by your attending doctor. The fee charged by your doctor in completing this form will be borne by yourself.
- It is mandatory to enclose copies of all reports, including resting ECGs, exercise stress tests, troponin results, enzymes assays, isotope studies, imaging, coronary angiography, blood tests, ultrasound, biopsy, histopathology report, CT scans, other imaging studies, laboratory evidence and any relevant hospital reports that are available.

IMPORTANT NOTES FOR ATTENDING DOCTOR

You may find that some of our questions overlap. Please ensure that questions of all relevant Sections in our Claim Form Part II are answered to the best of your knowledge as we will refer to the information provided when processing the claims.

To enable us to proceed with the claim, it is mandatory to enclose copies of all reports, including resting ECGs, exercise stress tests, troponin results, enzymes assays, isotope studies, imaging, coronary angiography, blood tests, ultrasound, biopsy, histopathology report, CT scans, other imaging studies, laboratory evidence and any relevant hospital reports that are available.

AIA SINGAPORE
CRITICAL ILLNESS CLAIM (COMMON DEFINITION)

POLICY NO.

PART I (To be completed by Insured)

Name of insured		NRIC/FIN/Passport No.	
Mailing Address		Age	Sex

1 NATURE OF CLAIM AND RELATED DETAILS:

a. Which critical illness are you claiming for?

_____

b. Describe the symptoms, including duration and date of onset.

_____

_____

c. The name and address of the doctor whom you first consulted for this illness.

_____

d. The name and address of your regular doctor.

_____

2 RECORD OF MEDICAL CONSULTATION / HOSPITALIZATION:

a. Details of any other doctor(s) or specialist(s) whom you have consulted in connection with this illness.

	Name	Address	Date of consultation (MM/DD/YY)
1.			
2.			

b. Please give below details of any hospitalization in connection with this illness.

	Name of hospital	Date of admission (MM/DD/YY)	Date of discharge (MM/DDIYY)
1.			
2.			

3 OTHER INSURANCE:

a. Are you insured for similar benefits with any other Company? If 'yes', please state.

Name of Insurer	Amount of benefit	Have claim been submitted?

FSC/Insurance Representative's Name	FSC/Insurance Representative's Code	RNF Registration No.	Contact No.

PT0007013 (03/2012 06/2014 01/2016)

Name of Policy Holder / Claimant:	NRIC/FIN/Passport No.:

4 AUTHORISATION & DECLARATION

I/We hereby authorise, agree and consent to:

(a) persons and organizations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organizations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "**Third Parties**") disclosing and releasing to AIA Singapore, its associated persons/organizations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "**AIA Persons**"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "**Personal Data**"), relevant for the Purpose (defined below);

(b) the AIA Persons sharing the scope of sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;

(c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);

(d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "**Using**"/"**Use**") the Personal Data for the Purpose; and

(e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of any Personal Data for the Purpose.

Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, "**Purpose**" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore.

I/We declare that all information is complete, true and correct and that no information or materials have been withheld and that AIA Singapore will rely and act on the Information accordingly.

I/We acknowledge and accept that AIA Singapore shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.

This authorisation and declaration shall bind my/our successors and assignees, and remains valid, notwithstanding death or incapacity. I/We agree that a photocopy of this authorisation shall be effective and valid as the original.

Date _____ Signature/Thumbprint of insured _____

Note: No fees, commissions or charges of whatever nature are payable to agents or employees of the company in respect of this claim.

CONFIDENTIAL MEDICAL CERTIFICATE

PART II (To be completed by the attending doctor at Insured's expense)

Name of insured	NRIC/FIN/Passport No.

The claim is being filed for the following illness: (Please tick [✔] in the appropriate box)

			Sections to be completed:
1.	Heart Attack	☐	1, 2, 3 & 33
2.	Stroke	☐	1, 2, 4 & 33
3.	Coronary Artery By-pass Surgery	☐	1, 2, 5 & 33
4.	HIV Due to Blood Transfusion & Occupationally Acquired HIV	☐	1, 2, 6 & 33
5.	Angioplasty and Other Invasive Treatments for Coronary Artery Disease	☐	1, 2, 7 & 33
6.	Major Cancers	☐	1, 2, 8 & 33
7.	Fulminant Hepatitis	☐	1, 2, 9 & 33
8.	Primary Pulmonary Hypertension	☐	1, 2, 10 & 33
9.	Kidney Failure	☐	1, 2, 11 & 33
10.	Major Organ Transplant/Bone Marrow Transplantation	☐	1, 2, 12 & 33
11.	Multiple Sclerosis	☐	1, 2, 13 & 33
12.	Blindness (Loss of Sight)	☐	1, 2, 14 & 33
13.	Paralysis (Loss of use of Limbs)	☐	1, 2, 15 & 33
14.	Muscular Dystrophy	☐	1, 2, 16 & 33
15.	Alzheimer's Disease/Severe Dementia	☐	1, 2, 17 & 33
16.	Coma	☐	1, 2, 18 & 33
17.	Deafness (Loss Of Hearing)	☐	1, 2, 19 & 33
18.	Heart Valve Surgery	☐	1, 2, 20 & 33
19.	Loss of Speech	☐	1, 2, 21 & 33
20.	Major Burn	☐	1, 2, 22 & 33
21.	Surgery to Aorta	☐	1, 2, 23 & 33
22.	Terminal Illness	☐	1, 2, 24 & 33
23.	End-stage Lung Disease	☐	1, 2, 25 & 33
24.	End-stage Liver Disease	☐	1, 2, 26 & 33
25.	Motor Neurone Disease	☐	1, 2, 27 & 33
26.	Parkinson's Disease	☐	1, 2, 28 & 33
27.	Aplastic Anaemia	☐	1, 2, 29 & 33
28.	Benign Brain Tumour	☐	1, 2, 30 & 33
29.	Bacterial Meningitis	☐	1, 2, 31 & 33
30.	Encephalitis	☐	1, 2, 32 & 33

SECTION 1 GENERAL INFORMATION

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

a. Are you the Insured's usual medical physician? **YES** ☐ **NO** ☐

If 'Yes', over what period do your records extend? ___/___/___ **(MM/DD/YY)**

b. When did insured first consult you for this illness? ___/___/___ **(MM/DD/YY)**

c. What were the symptoms presented?

_____

_____

d. According to insured, how long had he/she been experiencing these symptoms?

_____

_____

e. How long do you feel the symptoms has lasted? Please provide reasons.

_____

_____

f. What is the diagnosis? _____

g. On which date was the diagnosis made? ___/___/___ **(MM/DD/YY)**

On which date was the Insured first made aware of it? ___/___/___ **(MM/DD/YY)**

h. Has the insured previously suffered from the illness or any related condition ticked [✔] above? **YES** ☐ **NO** ☐

If 'Yes', please give dates of consultations and the resulting diagnosis.

_____

i. Is there anything in the Insured's family history which would have increased the risk of this illness. **YES** ☐ **NO** ☐

If 'Yes', please give family history.

_____

Name of Patient: NRIC/Passport No./FIN No.:

SECTION 2 DETAILS OF DIAGNOSIS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

a. Please provide full and exact details of the diagnosis and its clinical basis.

SECTION 3 DETAILS OF THE INSURED'S ILLNESS

Heart Attack

a. What is the diagnosis?

b. Please describe the heart attack

i. Date of Attack ___/___/___ (MM/DD/YY)

	YES	NO
ii. Was there a current history of typical chest pain?	☐	☐
iii. Were there any changes in the ECG indicative of a myocardial infarction?	☐	☐
iv. Was there a serial elevation of cardiac enzymes documented?	☐	☐
v. Was there elevation of Troponin (T or I) documented? If yes, please state the date of test and its reading	☐	☐
vi. Was left ventricular ejection fraction taken 3 months or more after the event? If yes, please state the date it was done and its percentage:	☐	☐

vii. Date of return to normal activities and/or the Insured's present limitations, physical and mental. ___/___/___ (MM/DD/YY)

c. Was there death of a portion of the heart muscle? YES ☐ NO ☐

d. Please enclose copies of all reports, resting ECGs, exercise stress tests, troponin results, enzymes assays, isotope studies, imaging (echocardiograms), coronary angiography and any relevant hospital reports that are available.

SECTION 4 DETAILS OF THE INSURED'S ILLNESS

Stroke

a. What is the diagnosis?

b. Please describe the episode.

i. Date of episode ___/___/___ (MM/DD/YY)

ii. Nature of the episode _____

iii. Duration of the acute symptoms _____

iv. Date of return to normal activities. ___/___/___ (MM/DD/YY)

c. i. Please comment on any neurological sequelae which lasted more than 24 hours

	YES	NO
ii. Is this a Transient Ischaemic Attack?	☐	☐
iii. Have these sequelae lasted at least 6 weeks after the events?	☐	☐

iv. How long have these sequelae been present since the initial episode? Please give the number of days/months _____

v. What are the insured's present limitations, physical and mental?

d. Has there been an infarction of brain tissue, cerebral haemorrhage, thrombosis or embolization from an extracranial source? _____

	YES	NO
e. Was the brain damaged due to an accident or injury, infection,vasculitis and inflammatory disease?	☐	☐
f. Is this a vascular disease that affects the eye or optic nerve?	☐	☐
g. Is this an ischaemic disorder of the vestibular system?	☐	☐

h. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedures, etc. and any relevant hospital reports that are available.

SECTION 5 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Coronary Artery By-pass Surgery

a. Please describe the extent of the disease.

i. Which arteries are involved and what is the degree of narrowing(%) in respect of each involved artery?

_____

	YES	NO
ii. Was coronary arteriography performed?	☐	☐

b. What is the nature of treatment?

i. Was open heart surgery performed?	☐	☐

ii. If yes, state the number and sites of grafts inserted.

_____

iii. What other forms of treatment were rendered?

_____

_____

c. Has the patient previously suffered from the above illness or any other cardiovascular disease? If yes, please provide the details.	☐	☐

_____

_____

d. Please enclose copies of all surgical reports, x-rays, CT scans, Thallium scans, and any other imaging studies, laboratory evidence, angiograms, etc. and any relevant hospital reports that are available.

SECTION 6 DETAILS OF THE INSURED'S ILLNESS

HIV Due to Blood Transfusion & Occupationally Acquired HIV

	YES	NO
a. Please describe the cause of infection.		
i. Was the infection due to blood transfusion?	☐	☐
ii. Was the blood transfusion medically necessary or given as part of a medical treatment?	☐	☐
iii. Was the blood transfusion received in Singapore?	☐	☐
If yes, when was the transfusion done?	/ / (MM/DD/YY)	
iv. Was the infection resulted from any other means including sexual activity and the use of intravenous drugs?	☐	☐

If yes, please state the likely cause

_____

_____

b. i. Is the source of infection established from the Institution that provided the blood transfusion?	☐	☐
ii. Is the Institution able to trace the origin of the HIV tainted blood?	☐	☐
c. Is the patient suffering from Thalassaemia Major or Haemophilia?	☐	☐
d. Is the occupation of the Insured a medical practitioner, houseman, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in Singapore?	☐	☐

If yes, please state the actual occupation _____

i. Was there an accident whilst the patient was carrying out the normal professional duties of his occupation in Singapore?	☐	☐
If yes, please state the exact date of accident.	/ / (MM/DD/YY)	
ii. Was the accident involved a definite source of the HIV infected fluids?	☐	☐
iii. Was an HIV antibody test done before the accident occurred?	☐	☐
iv. Was an HIV antibody test done after the accident occurred?	☐	☐
If yes, please state the exact date of test. What was the result? _____	/ / (MM/DD/YY)	

_____

SECTION 7 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Angioplasty and other invasive treatment for Coronary Artery

a. Please describe the extent of the disease.

i. Which arteries are involved and what is the degree of narrowing(%) in respect of each involved artery?

_____

ii. Name of the procedure: _____

	YES	NO
iii. Was balloon angioplasty, atherectomy or laser treatment done? If yes, state which treatment was done: _____	☐	☐
iv. Was the above treatment done due to prophylactic purposes?	☐	☐
v. Were the symptoms sufficiently severe to indicate that the Insured's future level of exercise tolerence would be restricted at a minimal level to prevent further episodes of chest pain?	☐	☐
vi. Was there a specialist medical opinion which defines the need to limit exercise so as to minimize moderate to severe anginal pain?	☐	☐
vii. Has the Insured been prescribed anti-anginal medication to limit chest pain for a minimum period of 6 months?	☐	☐

b. Please enclose full reports from Cardiologist and copies of all reports including angiography, x-rays, CT scans, ultrasound or other imaging studies, ECGs, surgical reports, laboratory evidence, etc. and any relevant hospital reports that are available.

SECTION 8 DETAILS OF THE INSURED'S ILLNESS

Major Cancers

(Besides Female Cancer rider, all cancers exclude Carcinoma-in-Situ of the Breasts, Cervical Dysplasia CIN-1, CIN-2 and CIN-3)

a. Please describe the extent of the disease.

i. What is the histological diagnosis of the disease?

_____

ii. What is the staging of the Tumour? _____

iii. Is the disease completely localized? _____

	YES	NO
iv. Is there spread of malignant cells to lymph nodes or distant part of the body? If yes, please describe degree of regional nodal involvement and/or spread to distant parts of the body. _____	☐	☐
v. Is the tumour histologically described as pre-malignant or non-invasive, including, but not limited to Carcinoma-in-Situ of the Breasts, Cervical Dysplasia CIN-1, CIN-2 and CIN-3?	☐	☐
vi. Was the tumour present due to HIV/AIDS infection?	☐	☐

b. To be completed ONLY if diagnosis is skin cancer, prostate cancer, thyroid and bladder cancer or chronic lymphocytic leukaemia.

i. For skin cancer, is the tumour histologically described as hyperkeratoses, basal cell and squamous skin cancers?	☐	☐
ii. For melanomas cancers, is the lesion of less than 1.5mm Breslow thickness, nor less than Clark level 3?	☐	☐
iii. For prostate cancer, is the tumour histologically described as TNM Classification T1a or T1b or another equivalent or lesser classification, $T_1N_0M_0$?	☐	☐
iv. For thyroid or bladder cancer, is the tumour histologically described as Papillary micro-carcinoma of less than 1 cm in diameter?	☐	☐
v. For Chronic Lymphocytic Leukaemia, is the disease classified as lesser than RAI Stage 3?	☐	☐

c. What is the nature of treatment?

Surgical ☐ Radiotherapy ☐

Chemotherapy ☐ Palliative ☐

Please provide details of procedure(s).

_____

_____

d. Investigations:

i. Is biopsy of the tumour performed?	☐	☐

ii. Please enclose copies of all reports including biopsy, cytology reports, x-rays, CT scans, other imaging studies, laboratory evidence, surgical reports, etc. and relevant hospital reports that are available.

SECTION 9 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Fulminant Hepatitis

a. Please describe the extent of the illness.

i. What is the diagnosis and etiological agent:

_____

ii. Approximate date of onset. ___/___/___ **(MM/DD/YY)**

	YES	NO
iii. Is there a rapid decreasing liver size?	☐	☐
iv. Is there a submassive to massive necrosis of the liver?	☐	☐
v. Is there a rapid deterioration of liver function?	☐	☐
vi. Was there jaundice?	☐	☐
vii. Was there hepatic encephalopathy?	☐	☐

b. What is the current condition of the Insured and what is the prognosis?

_____

_____

c. Please enclose copies of all reports including liver function test, ultrasound, MR and other imaging studies, laboratory evidence, etc. and any relevant hospital reports that are available.

SECTION 10 DETAILS OF THE INSURED'S ILLNESS

Primary Pulmonary Hypertension

a. What was the extent of the pulmonary arterial hypertension?

	YES	NO
i. Was there dyspnea and fatigue?	☐	☐
ii. Was there increase in left atrial pressure of at least 20 units or more?	☐	☐
iii. Was there pulmonary resistance of at least 3 units above normal?	☐	☐
iv. Was there pulmonary artery pressure of at least 40mmHg?	☐	☐
v. Was there pulmonary wedge pressure of at least 6mmHg?	☐	☐
vi. Was there right ventricular end-diastolic pressure of at least 8mmHg?	☐	☐
vii. Was there right ventricular hypertrophy, dilation and signs of right heart failure and decompensation?	☐	☐
b. Was the patient able to engage in any physical activity without discomfort?	☐	☐
c. Are the symptoms present even at rest?	☐	☐
d. i. Was there permanent physical impairment of at least class IV of the NYHA classification of cardiac impairment?	☐	☐

ii. If not, what is the NYHA classification for the current condition?

_____

e. In your medical opinion what was the cause of the pulmonary arterial hypertension.

_____

f. Please enclose copies of all reports including x-rays, ECGs, ultrasound, cardiac catherization, laboratory tests, pulmonary function studies etc, and any relevant hospital reports that are available.

SECTION 11 DETAILS OF THE INSURED'S ILLNESS

Kidney Failure

a. Please describe the extent of the kidney failure.

	YES	NO
i. Has the Insured's renal disease reached end-stage?	☐	☐
If yes, what was the exact date of diagnosis ___/___/___ **(MM/DD/YY)**		
ii. Are both kidneys involved?	☐	☐
iii. Is the Insured undergoing regular peritoneal dialysis or haemodialysis?	☐	☐
If yes, what was the date of commencement? ___/___/___ **(MM/DD/YY)**		
iv. Has renal transplantation been performed?	☐	☐
If yes, when was it done? ___/___/___ **(MM/DD/YY)**		
v. Was the patient a recipient of the renal transplant?	☐	☐
vi. Is the renal dialysis/transplantation required as a life-saving procedure?	☐	☐

b. Please enclose copies of all reports including x-rays, blood tests, other laboratory tests, cystoscopy report, pyelograms, ultrasound, and biopsy reports, surgical procedures and any relevant hospital reports that are available.

Name of Patient: NRIC/Passport No./FIN No.:

SECTION 12 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Major Organ Transplant / Bone Marrow Transplantation

a. Please describe the transplant operation.

i. Which of the organ is involved? _____

ii. What is the date of operation? ____/____/____ **(MM/DD/YY)**

iii. What is the prognosis? _____

_____

iv. Was the transplant resulted from an irreversible end stage failure of the relevant organ? **YES** ☐ **NO** ☐

b. Please enclose copies of all reports including x-rays, CT scans, ultrasound or other studies, ECG, surgical reports, laboratory evidence etc, and any relevant hospital reports that are available.

SECTION 13 DETAILS OF THE INSURED'S ILLNESS

Multiple Sclerosis

a. Please describe the extent of the disease. **YES** **NO**

i. Is there a history of repeated relapse and remission or a steady progressive disability? ☐ ☐

ii. Are there lesions producing well-defined neurological deficits involving the optic nerves, brain stem and spinal cord which occurred over a continuous period of at least 6 months? ☐ ☐

iii. Are there signs and symptoms of multiple lesions? ☐ ☐

iv. Was the neurological damages caused by SLE or HIV/AIDS. ☐ ☐

If yes, what was the cause? _____

b. Date of return to normal activities. ____/____/____ **(MM/DD/YY)**

c. What are the Insured's present limitations, physical and mental?

_____

_____

d. Please enclose copies of all neurological reports, x-rays, ECGs, ultrasound or other imaging studies, laboratory tests, biopsy reports, etc, and any relevant hospital reports that are available.

SECTION 14 DETAILS OF THE INSURED'S ILLNESS

Blindness (Loss of Sight)

a. Please describe the extent of the blindness.

i. When was the date of onset? ____/____/____ **(MM/DD/YY)**

ii. What is the visual acuity of both eyes at present?

Left _____ Right _____

iii. What forms of treatment were rendered?

_____

_____

iv. What is the prognosis?

_____

_____

v. Will further surgery improve his/her sight? **YES** ☐ **NO** ☐

If yes, what kind of surgery will be necessary?

_____

b. What was the cause of blindness?

_____ ☐ ☐

_____

c. Please enclose copies of all reports including ophthalmologist's reports, CT scans and any other relevant hospital reports that are available.

SECTION 15 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Paralysis (loss of Use of Limbs)

a. Please describe the extent of the paralysis.

i. Date of onset ____/____/____ (MM/DD/YY)

ii. The areas of involvement. _____

_____

	YES	NO
iii. Is the loss of use of the involved limbs considered complete and permanent?	☐	☐

If yes, please provide basis for prognosis. _____

_____

b. Was the paralysis caused by self-inflicted injuries?	☐	☐

If not, what was the cause.

_____

_____

c. Please enclose copies of all reports including x-rays, CT scans, ultrasound or other studies, ECG, surgical reports, laboratory evidence etc, and any relevant hospital reports that are available.

SECTION 16 DETAILS OF THE INSURED'S ILLNESS

Muscular Dystrophy

a. Please describe the cause of infection.

	YES	NO
i. Is there evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex?	☐	☐

If yes, please describe findings. _____

_____

ii. Which are the muscles involved? _____

_____

b. i. Was the diagnosis confirmed by an electromyogram?	☐	☐
by muscle biopsy?	☐	☐

c. Is the patient able to perform (whether aided or unaided) the following:

i. Ability to wash and bathe oneself?	☐	☐
ii. Ability to dress and undress oneself?	☐	☐
iii. Ability to move independently in or out of bed or a chair?	☐	☐
iv. Ability to move indoors from room to room on level surfaces?	☐	☐
v. Ability to attend to one's own toilet needs?	☐	☐
vi. Ability to feed oneself?	☐	☐

d. Please enclose copies of all neurological reports, electromyogram studies, muscle biopsy, laboratory tests, etc, and any relevant hospital reports that are available.

SECTION 17 DETAILS OF THE INSURED'S ILLNESS

Alzheimer's Disease / Severe Dementia

a. What is the age of onset of Alzheimer's Disease? _____

b. Please describe the extent of the disease.

	YES	NO
i. Is there evidence of deterioration or loss of intellectual capacity?	☐	☐
ii. Is there abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of Insured?	☐	☐

If yes, please describe findings. _____

_____

iii. Did the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric illness and any drug or alcohol related organic disorder?	☐	☐

c. Please enclose copies of questionnaires or test reports or any relevant hospital reports that are available.

SECTION 18 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Coma

a. Please describe the extent of the coma.

i. Date of onset. ____/____/____ (MM/DD/YY)

ii. Is there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for at least 96 hours? YES ☐ NO ☐

iii. Was there brain damage resulting in permanent neurological deficit? YES ☐ NO ☐

iv. Has the sequelae lasted more than 30 days from the onset of the coma? YES ☐ NO ☐

b. What was the cause of coma?

_____

_____

c. Please enclose copies of all reports, neurological reports, x-rays, CT scans, MR and other imaging studies, laboratory test, surgical reports, and any relevant hospital reports that are available.

SECTION 19 DETAILS OF THE INSURED'S ILLNESS

Deafness (loss of Hearing)

a. Please describe the extent of the loss of hearing.

i. Date of onset. ____/____/____ (MM/DD/YY)

ii. Was the diagnosis confirmed by an audiometric and sound-threshold? YES ☐ NO ☐

iii. Is the loss of hearing considered total and irreversible? YES ☐ NO ☐

iv. Is there a loss of at least 80 decibels in all frequencies of hearing? YES ☐ NO ☐

b. What was the cause of the loss of hearing?

_____

_____

c. Please enclose copies of all audiometric and sound-threshold reports, x-rays, laboratory tests, surgical reports, and any relevant hospital reports that are available.

SECTION 20 DETAILS OF THE INSURED'S ILLNESS

Heart Valve Surgery

a. Please describe the extent of the disease.

i. Date of onset of the heart valve defects. ____/____/____ (MM/DD/YY)

b. Was open heart surgery performed?

i. If yes, state the surgical procedure used to correct the valvular problem.

_____

c. Please enclose copies of all surgical reports, x-ray, CT Scans, and any other imaging studies, laboratory evidence, angiograms etc, and any relevant hospital reports that are available.

SECTION 21 DETAILS OF THE INSURED'S ILLNESS

Loss of Speech

All psychiatric related causes are excluded.

a. Please describe the extent of the loss of speech.

i. Date of onset. ____/____/____ (MM/DD/YY)

ii. Duration of the loss of speech?

_____

iii. Is the loss of speech considered total and irrecoverable? YES ☐ NO ☐

b. What was the cause of the loss of speech?

_____

c. Please enclose copies of all reports from (Ear, Nose and Throat) specialist, x-ray, laboratory tests, surgical reports, and any relevant hospital reports that are available.

SECTION 22 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Major Burn

a. Please describe the extent of the major burns.

i. Date of onset. ____/____/____ (MM/DD/YY)

ii. Is the burns considered Third Degree Burns? If so, please describe the extent (in percentages) of the bums covering the body surface. YES ☐ NO ☐

_____

_____

b. What was the cause of the major burns?

_____

_____

c. Please enclose copies of surgical reports and all relevant hospital reports that are available.

SECTION 23 DETAILS OF THE INSURED'S ILLNESS

Surgery to Aorta

a. Please describe the extent of the disease.

i. What is the diagnosis? _____

ii. Date of onset of the diseased aorta ____/____/____ (MM/DD/YY)

b. Was excision and surgical replacement of the diseased aorta with a graft performed? YES ☐ NO ☐

c. Was the surgery performed using minimally invasive or intra arterial techniques? ☐ ☐

d. Please enclose copies of all surgical reports, x-rays, CT scans, any other imaging studies, laboratory evidence, angiograms etc, and any relevant hospital reports that are available.

SECTION 24 DETAILS OF THE INSURED'S ILLNESS

Terminal Illness

a. Please describe the terminal illness.

i. Date of onset ____/____/____ (MM/DD/YY)

ii. What is the diagnosis?

_____

iii. What is your prognosis?

_____

iv. What is the nature of treatment?

_____

v. In your opinion, is the condition highly likely to lead to death within 12 months? YES ☐ NO ☐

vi. Is the condition present due to HIV infection? ☐ ☐

b. Please enclose copies of all reports, radiological procedures, CT scans, x-rays, any other imaging procedures, laboratory evidence, and any relevant hospital reports that are available.

SECTION 25 DETAILS OF THE INSURED'S ILLNESS

End Stage Lung Disease

a. Diagnosis and etiology: _____

_____

_____

b. Please describe the extent of the lung failure.

i. Has the Insured's lung disease reached end-stage?
If yes, please state the exact date. ____/____/____ (MM/DD/YY)

ii. What is the FEV1 of the Insured?

_____

_____

iii. Is the Insured undergoing extensive and permanent oxygen therapy for hypoxemia? YES ☐ NO ☐

iv. What is the Arterial blood gas analysis (PaO_2) of the Insured?

_____

c. Please enclose copies of all reports including x-ray, blood test, other laboratory tests, brochoscopy reports, bronchograms, ultrasound, and biopsy reports, surgical procedures and any relevant hospital reports that are available.

Name of Patient: NRIC/Passport No./FIN No.:

SECTION 26 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

End-stage Liver Failure

a. What is the diagnosis? _____

_____

_____

b. Please describe the extent of the illness.

i. Approximate date of onset. ___/___/___ **(MM/DD/YY)**

	YES	NO
c. Is there end stage liver failure?	☐	☐
If yes:		
i. Is there permanent jaundice?	☐	☐
ii. Is there ascities?	☐	☐
iii. Is there hepatic encephalopathy?	☐	☐

d. What was the cause of the liver failure?

_____

_____

e. Was the liver disease secondary to alcohol or drug abuse?	☐	☐

f. What is the current condition of the Insured and what is the prognosis?

_____

_____

g. Please enclose copies of all reports including liver function test, ultrasound, MR and other imaging studies, laboratory evidence and any relevant hospital reports that are available.

SECTION 27 DETAILS OF THE INSURED'S ILLNESS

Motor Neurone Disease

a. Please describe the extent of the disease.

i. Date of onset. ___/___/___ **(MM/DD/YY)**

ii. What was your diagnosis? _____

_____

_____

	YES	NO
iii. Is there progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones including spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis & primary lateral sclerosis?	☐	☐

If yes, please elaborate. _____

_____

_____

b. Please enclose copies of all reports, radiological procedures, CT scans, laboratory evidence, other imaging procedure, etc, and any relevant hospital reports that are available.

SECTION 28 DETAILS OF THE INSURED'S ILLNESS

Parkinson's Disease

a. Please describe the extent of the disease.

i. Date of onset. ___/___/___ **(MM/DD/YY)**

ii. What was your diagnosis? _____

_____

iii. What is the cause of the disease? _____

_____

	YES	NO
b. Is the Insured able to perform without assistance the following:		
i. Ability to wash and bathe oneself?	☐	☐
ii. Ability to dress and undress oneself?	☐	☐
iii. Ability to move independently in or out of bed or a chair?	☐	☐
iv. Ability to move indoors from room to room on level surfaces?	☐	☐
v. Ability to attend to one's own toilet needs?	☐	☐
vi. Ability to feed oneself?	☐	☐

c. Please enclose copies of all reports, radiological procedures, CT scans, laboratory evidence, other imaging procedures, etc, and any relevant hospital reports that are available.

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

SECTION 29 DETAILS OF THE INSURED'S ILLNESS

Aplastic Anaemia

a. Please describe the extent of the disease.

i. Date of onset. ___/___/___ **(MM/DD/YY)**

ii. What was your diagnosis? _____

_____

b. What is the haemoglobin level, red cell count, white cell count and platelet count?

_____

c. What is the nature of treatment?

	YES	NO
(a) blood product tranfusion	☐	☐
(b) marrow stimulating agents	☐	☐
(c) immunosuppressive agents	☐	☐
(d) bone marrow transplantation	☐	☐

d. Please enclose copies of all reports, radiological procedures, CT scans, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.

SECTION 30 DETAILS OF THE INSURED'S ILLNESS

Benign Brain Tumour

a. Please describe the extent of the Benign Brain Tumour.

i. Date of onset. ___/___/___ **(MM/DD/YY)**

ii. When was the patient informed of the diagnosis?

_____

_____

iii. Please provide the detailed location of the tumour.

_____

_____

	YES	NO
iv. Is the tumour life threatening?	☐	☐
v. Has the tumour caused damage to the brain?	☐	☐
vi. Has the patient undergone surgical removal?	☐	☐
vii. Has the tumour caused a permanent neurological deficit?	☐	☐
viii. Is the tumour confirmed by imaging studies such as CT scan or MRI?	☐	☐

b. Please provide the copy of CT scan or MRI report.

SECTION 31 DETAILS OF THE INSURED'S ILLNESS

Bacterial Meningitis

a. Please describe the extent of the disease.

i. Date of diagnosis. ___/___/___ **(MM/DD/YY)**

ii. When was the patient informed of the diagnosis? ___/___/___ **(MM/DD/YY)**

	YES	NO
iii. Was the diagnosis confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture?	☐	☐

iv. Date of return to normal activities. ___/___/___ **(MM/DD/YY)**

v. What are the Insured's present limitations, physical and mental?

_____

_____

	YES	NO
vi. Were there any neurological deficits which has lasted for at least six weeks?	☐	☐
vii. Are these neurological deficits permanent?	☐	☐

viii. What are these neurological deficits?

_____

_____

ix. Was the condition present due to HIV/AIDS infections?	☐	☐

b. Please enclose copies of all surgical reports, x-rays, CT scans, and any other imaging studies, laboratory evidence, CSF culture etc. and any relevant hospital reports that are available.

Name of Patient: NRIC/Passport No./FIN No.:

SECTION 32 DETAILS OF THE INSURED'S ILLNESS

DETAILS of 'Yes' answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

Encephalitis

a. Please describe the extent of the illness.

i. Date of diagnosis. ___/___/___ **(MM/DD/YY)**

ii. When was the patient informed of the diagnosis? ___/___/___ **(MM/DD/YY)**

iii. Date of return to normal activities. ___/___/___ **(MM/DD/YY)**

iv. Was there any significant and serious permanent neurological deficit? **YES** ☐ **NO** ☐
If yes, what are they? _____

v. Are the permanent neurological deficit documented for at least six (6) weeks? ☐ ☐
Please provide details.

vi. What are the Insured's present limitations, physical and mental?

vii. Was the condition present due to HIV/AIDS infection? ☐ ☐

b. Please enclose copies of all surgical reports, EEG, X-rays, CT scans and any other imaging studies, laboratory evidence, CSF culture etc. and any relevant hospital reports that are available.

SECTION 33 DETAILS OF THE INSURED'S ILLNESS

a. Please provide name and address of doctor who referred him/her to you.

	YES	**NO**
b. Has the Insured suffered from/been treated for any other illness(es)/complaints other than this Critical Illness?	☐	☐
c. Is there any further information which in your opinion will assist us in assessing this claim? If so, please furnish such information.	☐	☐
d. Will you agree and authorize us to release this medical information if such disclosure is required by the Financial Industry Disputes Resolution Centre Ltd (FIDReC) of Singapore or any proper Government Authority?	☐	☐

To be completed by Attending Physician / Specialist

Name of Doctor: _____

Qualification : _____

Address/Official Stamp :

Signature : _____

Date : _____