



**AVIVA LTD**

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**DREAD DISEASE CLAIM – PHYSICIAN’S STATEMENT**

Please complete all the sections in this report to the best of your knowledge. Any medical report fee will be borne by the claimant. In order for a claim under this Policy to be considered, either of the following definitions must be satisfied: -

**CANCER**

**Definition A**

A disease manifested by the presence of a malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue as evidenced by definite histology, laboratory or radiology evidences. The term “Cancer” shall include Leukaemia and Lymphoma but shall exclude pre-malignant tumours, non-invasive cancers in-situ, tumours in the presence of any human immuno-deficiency virus and skin cancer other than malignant melanoma.

**Definition B**

A malignant tumour characterised by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. This diagnosis must be supported by histological evidence of malignancy and confirmed by an oncologist or pathologist.

The following are excluded:

- a) Tumours showing the malignant changes of carcinoma-in-situ and tumours which are 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;
- b) Hyperkeratoses, basal cell and squamous skin cancers, and melanomas of less than 1.5mm Breslow thickness, or less than Clark Level 3, unless there is evidence of metastases;
- c) Prostate cancers histologically described as TNM Classification T1a or T1b or Prostate cancers of another equivalent or lesser classification, T<sub>1</sub>N<sub>0</sub>M<sub>0</sub> Papillary micro-carcinoma of the Thyroid less than 1 cm in diameter, Papillary micro-carcinoma of the Bladder, and Chronic Lymphocytic Leukaemia less than RAI Stage 3; and
- d) All tumours in the presence of HIV infection.

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Name of Patient : \_\_\_\_\_ Sex: M / F Age: \_\_\_\_\_

NRIC/Passport No.: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Company : \_\_\_\_\_ Occupation : \_\_\_\_\_

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**PART A – PATIENT HISTORY**

- 1) Please state over what period do your records extend:
  - a) Date of first consultation:
  - b) Date of last consultation:
  - c) Number of consultations during the above period:
  - d) What were the reasons of consultations (with dates)?

2) Are you the patient's usual doctor? **YES / NO**

a) If "Yes", since what date?

b) If "No", please advise the name of the regular attending doctor and address of clinic / hospital.

3) Was the patient referred to you? **YES / NO**

a) If "Yes", please advise (i) date referred, (ii) reason the patient was referred, (iii) name of doctor recommending the referral, and (iv) name and address of clinic / hospital.

b) If "No", how did he / she come to consult at your clinic or hospital (e.g. A&E)?

4) Have you referred the patient to any other doctor(s)? **YES / NO** If "Yes", please state (a) date referred, (b) reasons for referral, (c) name of doctor referred to, and (d) address of clinic/hospital.

5) Besides Cancer, does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. diabetes mellitus, hypertension, hyperlipidaemia, anaemia, cysts, etc)?  
**YES / NO** If "Yes", please advise:

a) <u>Details of Symptoms</u>	<u>Exact Diagnosis</u>	<u>Date of Diagnosis</u>	<u>Treatment</u>
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b) Name of the Doctor(s) (and Clinic Address) whom the patient consulted for the condition(s) stated in (a) above

c) What is your source of the above information?

- 6) Are you aware of any members of the patient's family having suffered from cancer or any similar condition, or which would have increased the risk of cancer? **YES / NO** If "Yes", please advise which family members, nature of illness and date of diagnosis.
- 7) Please give details of the patient'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.
- 8) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of alcohol consumption per day and the source of this information.

**PART B - CONSULTATION FOR PRESENT ILLNESS/INJURY (IES)**

- 1) Are you aware that the patient suffered from Cancer? **YES / NO**
- 2) a) Date the patient FIRST noticed symptoms of Cancer:
- b) What symptoms did the patient notice then?
- c) Date the patient FIRST consulted a doctor for the symptoms:
- 3) a) Date you first attended to the patient for Cancer and / or symptoms related to it:
- b) Details of the symptoms presented when the patient first consulted you:
- c) Duration of symptoms:  
(i) According to the patient:  
(ii) In your opinion:
- d) Underlying cause(s) of the symptoms:
- e) Exact diagnosis of the condition:



10) Are you aware of any other doctor(s) (in Singapore or overseas) whom the patient consulted for the above illness or any other related diseases? **YES / NO** If “Yes”, please advise:

<u>Name of Doctor and Name &amp; Address of Clinic / Hospital</u>	<u>Date of First &amp; Last Consultation</u>	<u>Reason &amp; Treatment</u>
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11) Is there anything in the patient’s personal medical history which would have increased the risk of Cancer? **YES / NO** If “Yes”, please give details:

<u>Exact Diagnosis</u>	<u>Date of Diagnosis</u>	<u>Name of Doctor &amp; Address of Clinic/Hospital</u>
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12) Has active treatment and therapy now been rejected in favour of relief of symptoms? **YES / NO** If “Yes”, please provide full details why this view / course of action is taken.

13) Can you confirm that the advent of death is highly probable within (a) **6** months, (b) **12** months? **YES / NO** If “Yes”, please describe and provide supporting medical documents, reports, etc. that support this view.

14) Is the tumour or cancer in any way related or in the presence of any Human Immuno-Deficiency virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? **YES / NO** If “Yes”, please state date HIV was diagnosed.

15) Please describe and elaborate on the nature and severity of the patient’s disability and limitation, if any.

16) Had the patient ever been hospitalised before? **YES / NO** If “Yes”, please advise:

<u>Name of hospital</u>	<u>Reason &amp; Treatment</u>	<u>Date of Admission &amp; Discharge</u>
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17) Please state and attach copies of all reports such as specialist or hospital reports and investigation reports (biopsy, histopathology, cytology reports, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, etc.).

18) Do you have any other information that may be important for our assessment of the claim?  
**YES / NO** If “Yes”, please provide details.

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Signature of Physician : .....

Name of Physician : .....

Designation : .....

Clinic's Address & Stamp: .....

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Date : .....