PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - Cancer/Terminal or Other Illnesses

Name of the Patient (Last name, First name, Middle name)	**Date of Birth**

The above person is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with his/her insurance policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

In order for the claim to be valid the following definition must be fulfilled :

***Cancer*. This means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukemia but excludes non-invasive cancers in situ, tumors in the presence of any Human Immuno-deficiency Virus and any skin cancer other than malignant melanoma.**

A. General

QUESTIONS	YES	NO	**Please give Details To "YES" Answers**
1. Are you the patient's usual Attending Physician? If yes, over what period do your records extend?	☐	☐	
2. When were you first consulted for this condition, and at that time, how long had symptoms been present?			
3. Has the patient previously suffered from the condition specified above or any possible related illness? If yes, please give dates of consultations and resulting diagnosis below	☐	☐	

Date of Consultation	Name of Physician	Hospital/Clinic	Diagnosis	Treatment

4. On which date did the patient become aware of the condition?	

B. Medical Details if Illness is <u>Cancer</u> (Write "NA" if question/s is/are not applicable).

1. Please provide dates with full and exact details of the diagnosis.	
2. What was the site or organ involved and the precise histology of the tumor ?	
3. What stage did the disease reach? Please describe using whichever staging classification is appropriate.	
4. Was the disease completely localized?	
5. Was there an invasion of adjacent tissues?	
6. Were regional lymph nodes involved?	
7. Were there distant metastasis?	
8. Is there anything in the patient's family history which would have increased the risk of cancer? Please Describe.	
9. If the diagnosis is Leukemia, please provide details of the actual type.	

NAME OF THE PATIENT: ______________________________
Last Name, First Name, Middle Name

9. In your opinion, does the condition suffered by your patient fulfill the definition of cancer stated above or overleaf this page?	
10. What is the prognosis of the patient's condition?	
11. In your opinion, would you classify present illness as terminal? If so, what's the life expectancy?	

C. Other details on Illness/es if not covered in Section B (non-cancer)

1. Please provide dates with full and exact details of the diagnosis.	
2. Did the patient undergo surgery? Please indicate the procedure performed.	
3. In cases of Parkinson's Disease, can you describe the specific condition or conditions of which the illness has affected the patient?	
4. Would the illness permanently prevent the insured from performing activities of daily living without assistance? Please describe these activities the patient is unable to do.	
5. What is/are the predisposing factor/s contributory to the illness of the patient? Please give exact details on the history of such illness.	
6. What is the prognosis of the patient's condition?	
7. Please give the name and address of all Consultants, Specialists or Hospitals to which your patient has been referred or attended for this condition.	
Name of Physician	**Address**

DECLARATION
I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION
I further authorize your Medical Director or any of his/her authorized representative or other person in your employ, to obtain or secure from me or any clinic, hospital or entity all the medical records of the above-named patient. A photographic copy of this authorization is valid as the original.

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Signature Over Printed Name of the Attending Physician

____
Specialization

____
Date

Address : ______________________________
License No: ______________________________