ZURICH

Claim No. (For Office Use Only)										
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Confidential Medical Questionnaire – Heart Related Conditions

Instructions & Important Note:

- This form must be completed by the attending doctor (who is a registered Medical Practitioner qualified and licensed to practice western medicine and who is practising within the scope of his/her licensing/training) at claimant's expense.
- The attending doctor is required to tick (√) & complete the relevant part(s) below.
- If there is insufficient space, please use a separate sheet/s of paper for your response.

Part A : Details of Patient (Life Assured) - This section is Compulsory to be completed for all Critical Illnesses

1. Name		2. Gender	[ ] Male [ ] Female
3. New NRIC Number		4. Old IC No. / Passport No / Birth Certificate No.	
5. Age		6. Policy Number	

Important: Please enclose copies of ECGs, Cardiac Enzymes assays, Troponin I test, Troponin T test, Echocardiogram, Post bypass report, angiogram report, Post Percutaneous Transluminal Coronary Angioplasty (PTCA) report, and all reports including X-rays, CT scans, any other imaging studies, laboratory evidence, etc. and any relevant hospital reports that are available.

Part B : Details of Diagnosis - Question 1 to 5 is Compulsory to be completed for all Critical Illnesses

1 a Are you the patient's regular doctor? [ ] Yes [ ] No

b If Yes, since when? D D M M Y Y

2 a When were you first consulted for this illness? D D M M Y Y

b What were the symptoms / complaints? _____

c Date of onset of symptoms / complaints D D M M Y Y

Diagnosis

3 a Please state the full and exact diagnosis. _____

b When was the illness FIRST diagnosed? D D M M Y Y ____ am / pm

c When patient / patient's next of kin was First informed of the diagnosis? D D M M Y Y ____ am / pm

d What was / were the underlying cause(s)? _____

4 Is the current diagnosis related to

- [ ] Alcohol/Drugs
- [ ] Self-inflicted Injury
- [ ] Acquired Immune Deficiency Syndrome (AIDS) or Human Immuno-deficiency Virus (HIV) Infection
- [ ] Traumatic Injury
- [ ] Congenital
- [ ] None of the above

5 To your knowledge, has the patient suffered from any of the following illness / condition?

		Yes	No	Date of Onset	Name of Doctor/Clinic/Hospital
a	Hyperlipidemia				
b	Hypertension				
c	Diabetes				

d Any Other Illness or Disability, please specify. _____

Note: Question 6 & 7 is Compulsory to be completed for Heart Attack / Cardiomyopathy / Pulmonary Arterial Hypertension

6 a Please (√) tick the severity of cardiac impairment based on New York Heart Association (NYHA) classification. ☐ I ☐ II ☐ III ☐ IV

b Is the cardiac impairment likely to be permanent? ☐ Yes ☐ No

c Will the cardiac impairment improve? ☐ Yes ☐ No

d Please provide details of current limitations. _____

7 Name the surgeon who performed the procedure / surgery and hospital address.

a Name of the surgeon / doctor _____

b Full and address of the hospital _____

Part C : Details of Critical Illness - This section is applicable to specific Critical Illness only

Heart Attack

Did the patient have:

8 a Was there death of heart muscle due to inadequate blood supply (heart attack)? ☐ Yes ☐ No

b History of typical chest pain ☐ Yes ☐ No

c If Yes, when was the onset date and time of chest pain? D D M M Y Y _____ am / pm

d Any new ECG changes? ☐ Yes ☐ No

e If Yes, kindly provide details of ECG changes. ☐ ST elevation or depression ☐ Pathological Q waves ☐ T wave inversion ☐ Left bundle branch block

f Elevation of cardiac biomarkers ☐ Yes ☐ No

g If Yes, kindly provide the following details.

Cardiac Biomarker	Date of Test	Actual Reading with units
CK		
CPK-MB		
Troponin I		
Troponin T		

h Is the rise of the biomarker resulting from a percutaneous procedure for coronary artery disease? ☐ Yes ☐ No

Cardiomyopathy or Pulmonary Arterial Hypertension

9 a Details of investigations performed to confirm the diagnosis. _____

b Was there any Cardiomyopathy / Cardiac muscle impairment at present? ☐ Yes ☐ No

c Was there evidence of ventricular dysfunction? ☐ Yes ☐ No

d Cause of pulmonary hypertension ☐ without a known case ☐ result of other disease ie _____

e Was there any evidence of right ventricular failure? ☐ Yes ☐ No

Angioplasty and Other Invasive Treatments for Coronary Artery Disease / Coronary Artery Laser Therapy or other Invasive Coronary Procedure / Coronary Artery By-pass Surgery / Serious Coronary Artery Disease

10 a Date of Arteriography performed D D M M Y Y

b Was there any narrowing of the lumen of any major coronary arteries (NOT inclusive of branches)? ☐ Yes ☐ No

c If Yes, kindly provide the percentage (%) of the stenosis.

Major Artery	Date of Test	Percentage of Stenosis
Left Main Stem		
Circumflex Artery		
Left Anterior Descending		
Right Coronary Artery		

d Was there any narrowing of the lumen of any non-major coronary arteries inclusive of their branches)? ☐ Yes ☐ No

e If Yes, kindly provide the details. _____

f Please (√) tick the appropriate treatment.

☐ Open-Chest Coronary Artery Bypass Surgery
☐ Keyhole Bypass Surgery
☐ Coronary Artery Atherectomy
☐ Transmyocardial Laser Therapy
☐ EECP Device Insertion
☐ Coronary Angioplasty
☐ Coronary Laser Treatment
☐ Intra-Arterial Procedure
☐ Laser Procedure
☐ Others, please specify: _____

g Name and type of procedure / surgery performed _____

h Date of procedure / surgery performed D D M M Y Y _____ am / pm

i Name the site of coronary artery receiving the treatment. _____

Surgery to Aorta

11 a Please (√) tick the procedure / surgery performed.

☐ Thoracotomy
☐ Laparotomy
☐ Minimal Invasive Surgery to Aorta
☐ Others, please specify: _____

b Site of the aorta involved

☐ Thoracic Aorta
☐ Abdominal Aorta
☐ Branch(es) of Thoracic / Abdominal Aorta

c Date of procedure / surgery performed D D M M Y Y _____ am / pm

d Please (√) tick the objective of the procedure / surgery performed.

☐ To repair aortic aneurysm
☐ To correct aortic aneurysm
☐ To treat coarctation
☐ Others, please specify: _____
☐ An obstruction of the aorta
☐ A dissection of the aorta
☐ Traumatic injury of the aorta

Heart Valve Surgery / Heart Valve Replacement

12 a Please (√) tick the procedure / surgery performed.

☐ Open Heart Surgery
☐ Percutaneous Valvuloplasty
☐ Percutaneous Valve Replacement
☐ Percutaneous Valvotomy
☐ Key-hole Procedure
☐ Intra-Arterial Procedure

b Date of procedure / surgery performed D D M M Y Y _____ am / pm

c Please (√) tick the objective of the procedure / surgery performed.	☐ Valve Replacement ☐ Valve Repair ☐ Others, please specify: _____

Part D : Patient's Medical Information - This section is Compulsory to be completed for all Critical Illnesses

1. Please provide the name and address of all doctors, specialists, or hospital to which the patient has been referred or attended for this condition.

Consultation date(s)	Name of Doctor	Name and Address of Clinic / Hospital

2. (a) Has the patient previously suffered from this disease or any related illness? ☐ Yes ☐ No

(b) If Yes, please state the dates of consultations, diagnosis, name of doctor, name of clinic / hospital and the treatments / medications given.

Consultation Date(s)	Diagnosis	Name of Doctor	Name of Clinic / Hospital	Treatment / Medication(s) Given

3. In your opinion, is there any further information which will assist us in assessing the claim. If Yes, please furnish such information below.

I hereby certify that I have personally examined and treated the patient for the above injuries/illness. I hereby declare that all the answers and statement are complete and true to the best of my knowledge belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital/clinic.

Signature of Attending Physician	Name & Qualification of Attending Physician	Official Stamp of Hospital
Date	**Email Address**	**Telephone No**
D D M M Y Y Y Y		