CHUBB®

Living Benefit Claim - Coronary Artery Bypass Surgery
Part II - Attending Physician's Statement
(to be completed by attending physician at the claimant's own expenses)

Policy no. | | | | | | | | | | |

Patient's name	HKID Card/Passport no.	Date of birth DD MM YYYY / /	Sex	Age

Coronary Artery Bypass Surgery

The actual bypassing of an obstructed coronary artery with a saphenous vein or internal mammary artery graft. All other procedures such as angiography, angioplasty and laser treatments to unblock the obstructed artery are excluded.

A. General Information

1. Are you the patient's usual doctor? ☐ Yes ☐ No

   Since when (/ /) DD MM YYYY

2. When were you first consulted for this illness?

   (/ /) DD MM YYYY

3. What were the presenting symptoms?

4. According to the patient, how long had the symptoms been present?

   Since (/ /) DD MM YYYY **OR** for: years months days

5. What were the significant physical findings?

6. What was the exact diagnosis?

7. Date of diagnosis made?

   (/ /) DD MM YYYY

8. When was the patient informed of the diagnosis? (Please give exact date)

   (/ /) DD MM YYYY

9. If you are not the first who diagnosed for this illness, please give name and address of the doctor who informed the patient of the diagnosis.

   Doctor's name and address

10. Other physicians or medical facilities the patient has consulted for this condition.

Name of physician(s) &/or hospital(s)	Address(es)	Date of consultation(s) &/or period of confinement DD MM YYYY
		(/ /) To (/ /)
		(/ /) To (/ /)
		(/ /) To (/ /)

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B. Extent of Illness

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

   b. Has coronary arteriography been performed? ☐ Yes ☐ No when (/ /) DD MM YYYY
   If 'yes', please give date.

2. Investigations (x-rays, imaging studies, laboratory tests and angiograms)
   a. has angiograms been performed? ☐ Yes ☐ No when (/ /) DD MM YYYY
   b. please enclose copies of all reports including cytology reports, x-rays, CT scans, other imaging studies, laboratory evidence, surgical report etc, and any relevant hospital reports that are available.

3. Had the patient had any past history of the disease specified above or related illness? ☐ Yes ☐ No
   If 'yes', please give details of:-

Name of doctor	Date of consultation	Address of doctor	Exact diagnosis

4. What is the nature of treatment? Please give details of procedures.

5. What is the prognosis of the disease?

C. Other Information

1. Does the patient smoke cigarette or drink alcohol? If yes, please give details including the daily consumption and the duration of the habit.
   ☐ Yes ☐ No

Quantity	Type	Duration

2. Please state if the patient has suffered / been treated for any other illness(es) / complaints other than this critical illness.

3. Is there any further information, which in your opinion will assist us in assessing this claim?

I hereby certify that I have personally examined and treated the patient for the above illness and that the facts as given above present my opinion of his/her conditions.

Name of physician (with stamp)	Qualification	Signature	Date

Address: ___

Tel no.: ___

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