CHUBB®

# Living Benefit Claim - Renal Failure
# 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 |
|---|---|---|---|---|
| | | | | |

**Renal Failure**

End stage renal disease which presents as chronic irreversible failure of both kidneys to function, as a result of which renal dialysis is instituted or renal transplantation is carried out.

**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 ( / / ) |

## B. Extent of Illness

1. Please describe the extent of renal failure.
   a. What is the underlying kidney disease causing renal failure?

   b. Has the patient's renal disease reached end stage? If 'yes', please give date. ☐ Yes ☐ No ( / / ) DD MM YYYY

   c. Are both kidneys involved? If 'no', which side of kidney involved? ☐ Yes ☐ No

   d. Is the patient undergoing regular peritoneal dialysis or haemodialysis? ☐ Yes ☐ No
   If 'yes', please give date of starting dialysis. ( / / ) DD MM YYYY

   e. Has renal transplantation been performed?
   ☐ Yes when ( / / ) DD MM YYYY ☐ No

   f. Has renal transplantation been scheduled?
   ☐ Yes when ( / / ) DD MM YYYY ☐ No

2. Please give dates and results of any investigation performed, please enclose copies of all reports including X-rays, blood test, other laboratory tests, cystoscopy, pyelograms, ultrasound biopsy reports, surgical procedures and any relevant hospital reports that are available.

| Investigation | Date (DD/MM/YYYY) | Result |
|---|---|---|
| | | |

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 (DD/MM/YYYY) | 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?

6. Is the disease diagnosed to be directly or indirectly caused by or resulted from
   ☐ Self-inflicted injuries while sane or insane
   ☐ AIDS, AIDS-related complex or infection by HIV
   ☐ Willful misuse of any alcohol, narcotic or drug
   Please give details if any of the above item(s) is/are applicable.

## 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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