Initial Medical Attendant's Statement For Cancer/Major Illness Claims

(To be completed by a Registered Medical Practitioner at Claimant's expense).

Cigna Life Insurance New Zealand Limited
Majestic Centre, Level 24
100 Willis Street
PO Box 24 031, Wellington 6142
Tel: 0800 244 623
Fax: 04 470 9151
Email: claims.nz@cigna.com

Policy Number: ………………………………………………………………………

Patient's Name: ………..

Address: ....

Occupation: ....

Date of Birth: ..../........./.......... Sex: ....

Height: .... Weight: ....

1. Please describe the Nature of Illness: ....

   ....
2. Date these symptoms first appeared: ..../........./..........
3. Date you were first consulted for this condition: ..../........./..........
4. Date of Diagnosis: ..../........./..........
5. Has patient ever had same or similar or related condition? ☐ Yes ☐ No

   If "Yes" state when and provide details: ..../........./..........

   ....

   ....
6. Are you the patient's regular Medical Attendant? ☐ Yes ☐ No

   If "Yes" give duration of relationship: ....
7. Has there been or is there current involvement from another Medical Attendant or Specialist? ☐ Yes ☐ No

   If "Yes" give name, address and dates of attendance:

   ....

   ....
8. Please Provide history of medication and treatment:

   ....

   ....
9. What medication and treatment is ongoing or planned?, including dates:

   ....

   ....
10. What date did the patient cease work? ..../........./..........
11. If surgery was performed or is required, describe procedure and give dates: ....

    ....

    ....
12. If hospitalisation was or is required for surgery for the removal of cancer, provide dates:

    From: ..../........./.......... to: ..../........./..........
13. How long was or will the patient be totally disabled from attending to his/her usual occupation since the surgery for the removal of cancer?

    Totally disabled from: ..../........./.......... to: ..../........./..........

FOR OFFICE USE ONLY	DATE REQUESTED: 18/11/2020	DATE SENT: 18/11/2020	DATE RECEIVED:

14. Was the patient confined at home after being discharged from hospital? ☐ Yes ☐ No

From: ..../........./.......... to: ..../........./..........

....

15. Please indicate probable duration of disability and prognosis: ....

....

....

....

....

16. Has the patient requested medical evidence for this current disability to be issued for any other source?

(Insurance company, ACC, Work and Income NZ, employer) ☐ Yes ☐ No

If "Yes" provide details: ....

....

....

....

Please attach copies of relevant hospital and specialist reports.

Thank you for your assistance by completing this form. We are reliant on the information you provide to thoroughly assess our customer's individual situation and needs. We would welcome any additional comments and suggestions that you may have.

....

....

....

....

....

Name: .... Qualifications: ....
(Print)

Address: ....

.... Telephone: ....

Signature of Medical Attendant: Date: ..../........./..........