Cigna

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Initial Medical Attendant's Statement for Terminal Illness Claims

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

Patient's Name:

Policy No.

Address:

Date of Birth:

Sex:

Height:

Weight:

Claim Details

Please describe the nature of illness:

Date these symptoms first appeared:

Date you were first consulted for this condition:

Has your patient ever had same or similar or related condition? Yes ☐ No ☐

If "Yes" state when and provide details:

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

If "Yes give duration of relationship:

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:

Please provide history of medication and treatment: **Please attach copies of hospital and specialist reports including histology, imaging, and other relevant laboratory tests.**

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

What date did the patient cease work?

Please indicate probable duration of disability and prognosis:

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 and would welcome any additional comments and information that you may have.

Name:

Qualifications:

Address:

Mobile:

Email address:

Telephone:

Fax:

Signature of Medical Attendant:

Date: