Sun Life Malaysia Assurance Berhad* (197499-U)
Sun Life Malaysia Takaful Berhad* (689263-M)
Level 11, 338 Jalan Tuanku Abdul Rahman, 50100 Kuala Lumpur.
Telephone : (603) 2612 3600 Fascimile : (603) 2698 7035
Customer Careline : 1300-88-5055 sunlifemalaysia.com

CRITICAL ILLNESS MEDICAL REPORT (CANCER)

1. The following named is covered with **SUN LIFE MALAYSIA** against the happening of certain contingents events associated his/her health. A claim submitted in connection with CANCER and to enable us to assess the claim, we would be obliged if you would complete this Medical Report.
2. Any fees chargeable for the completion of this form shall be borne by the patient/ claimant.

Policy / Certificate / Contract No. : _____

Name of Patient : _____

NRIC / Birth Certificate No. / Passport No. : _____

Please attach certified true copies of all the relevant medical/laboratory tests available.

- ☐ Biopsy report
- ☐ Histopathology examination report (HPE)
- ☐ Blood and laboratory test results
- ☐ CT Scan / MRI / Radiological reports
- ☐ Bone marrow aspiration / Trephine biopsy report
- ☐ Surgical / Other reports : _____

1. (a) Are you the patient's regular attending doctor? ☐ Yes ☐ No

If yes, since when the patient has been consulting you : _____ (dd/mm/yyyy)

(b) Was the patient referred to you? ☐ Yes ☐ No If Yes, when? : _____ (dd/mm/yyyy)

(i) Name and address of the referral doctors : _____

(ii) Reasons for referral?: _____

_____ (Kindly furnish us a copy of the referral letter)

(iii) Please state the symptoms presented during the date of **FIRST** consultation and for how long the patient had been experiencing these symptoms.

Onset date (dd/mm/yyyy)	Symptoms

(iv) What was the underlying cause? _____

_____

2. (a) Was a biopsy of tumour performed? ☐ Yes ☐ No

If yes, please state date : _____ (dd/mm/yyyy)

Results : _____

(b) Give details of the type of tumour : _____

_____

(c) Please give an exact description of the site of the tumour. : _____

_____

(d) Please confirm the staging of the tumour. : _____

(e) When patient was first informed of the diagnosis? _____ (dd/mm/yyyy)

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3. (a) Type of investigations / tests done to confirm diagnosis.

(a)

Medical test	Please tick	Date
Biopsy		
Histopathology		
CT / MRI Scan		
Bone marrow aspiration / Trephine		
Tumour marker test		
Others, please specify :		

(b) Please confirm on the following(s)

(b)

		Remarks
Was there evidence of malignancy?	☐ Yes ☐ No	
Was the disease completely localized?	☐ Yes ☐ No	
Was there invasion of adjacent tissue?	☐ Yes ☐ No	
Were regional lymph nodes involved?	☐ Yes ☐ No	
Were there distant metastases?	☐ Yes ☐ No	

**Please provide us with a certified copy of the Histopathology Result confirming the above.*

(c) It is classified as:

(c)

Histological Classification	Please tick
Pre-malignant	☐ Yes ☐ No
Carcinoma in-situ	☐ Yes ☐ No
Is this the first occurance ? If no, when was the first occurance.	☐ Yes ☐ No : _____ (dd/mm/yyyy)
Having borderline malignancy	☐ Yes ☐ No
Having malignant potential	☐ Yes ☐ No
Non invasive	☐ Yes ☐ No
Malignant	☐ Yes ☐ No
Others, please specify :	

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(d) Is the tumour/cancer associated with the following?
You may 'tick' more than one.

(d)

Classification	Please tick
Tumours of the prostate histologically classified as T1N0M0.	☐ Yes ☐ No
Tumours of the thyroid histologically classified as T1N0M0.	☐ Yes ☐ No
Tumours of the urinary bladder histologically classified as T1N0M0.	☐ Yes ☐ No
Chronic Lymphocytic Leukemia less than RAI Stage 3	☐ Yes ☐ No
Cancer in the presence of HIV. If Yes, please state the HIV was first diagnosed.	☐ Yes ☐ No _____(dd/mm/yyyy)
Skin cancer other than malignant melanoma.	☐ Yes ☐ No
Carcinoma in situ of the skin (both Melanoma and Non-melanoma	☐ Yes ☐ No
Carcinoma in situ of the biliary system	☐ Yes ☐ No
Others, please specify : _____	

4. For Female Cancer Only

(a) Has the patient undergone the following test :

Medical test	Please tick	Date (dd/mm/yyyy)	Results
Mammogram			
Cone Biopsy			
Colposcopy			
Pap smear			
Others, please specify :			

(b) For Cervical Intraepithelial Neoplasia, please state classification :

☐ CIN I ☐ CIN II ☐ CIN III

5. Please provide the nature of treatment that has been carried out or of any future intention to do so.

Treatment	Details	Treatment Date (dd/mm/yyyy)	Prognosis
Surgery			
Radiotherapy			
Chemotherapy			
Palliative			
Others, please specify :			

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6. (a) Has the patient suffered from this illness or any related illnesses previously? Please give details.

Diagnosis	Yes / No	Onset date (dd/mm/yyyy)	Treating clinic / hospital
Hypertension	☐ Yes ☐ No		
Diabetes Mellitus	☐ Yes ☐ No		
Dyslipidaemia	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No		
Kidney Disease	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ No		
Others, please specify :			

(b) Please state from past records or from your personal knowledge, details of all illness, accidents, surgical operations or diseases from which the patient has suffered or for which he/she has been treated at your clinic from the first consultation until last consultation.

Date	Complaints & Symptoms	Diagnosis	Treatment

Please use separate sheet if space provided is insufficient

7. (a) Please state if there is anything in the patient's family history which would have increased the risk of illness.

_____

_____

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(b) Has the patient suffered from/been treated for any illnesses related to/cause this critical illness ? ☐ Yes ☐ No

_____

(c) What is your prognosis on the patient's condition?

_____

_____

(d) Is full recovery expected? ☐ Yes ☐ No

If Yes, please state approximate date : _____ (dd/mm/yyyy)

If No, please state the extent of recovery and approximate date of the stated extent of recovery.

_____

(e) Any further information which in your opinion will assist us in assessing the claim?

_____

_____

_____

"I HEREBY CERTIFY THAT THE INFORMATION STATED ABOVE ARE TRUE AND REPRESENT MY PROFESSIONAL MEDICAL OPINION OF HIS/HER CONDITION"

Date: ……

Signature : ……

Hospital / Clinic Stamp: ……

Doctor's Name: ……

Contact No : ……

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