

Supplement of Critical Illness & Total Disability Benefit Claim Form Part II-CANCER

The issue of this claim form is in no way an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or agents of the company with respect to this claim. YF Life Insurance International Ltd. will not be responsible for any fee the completion of this report.

Policy No. :			
Name of Patient :			
HKID Card/Passport No. :			
1)	Was there any diagnostic test, such as biopsy done for the patient? Please provide details: <u>Date</u> <u>Type(s) of Test</u> <u>Results/Diagnosis</u>		
2)	Has the patient suffered from any related illness/disease before? If so, please advise details: <u>Date</u> <u>Conditions</u> <u>Diagnosis</u> <u>Treatment(s)</u>		
3)	Based on your record, please list all hospitalization record(s) of the insured: <u>Admission Discharge Diagnosis Treatment Name of Hospital</u>		
4) a)	Regarding the suffering, please advise the followings: Is it pathologically confirmed characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue?		
b)	What is the site and/or organ involved?		
c)	What is the histology of the tumour or the malignant disease?		



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Name of Patient:	HKID Card No.:		
d) What staging classification is used and what is the tumour staging in this patient?			
e) Is there invasion of adjacent tissues?			
f) Is there any distant metastasis?			
g) Are regional lymph nodes involved?			
h) If the diagnosis is skin cancer, is it malignant melanoma?			
5) According to your record, had you ever heard of this patient suffered from any major/chronic/congenital disease? If so, please elaborate.			
6) When did you last see the patient? What was his/her condition?			
7) Any other information to supplement the above?			
I hereby certify that I have personally at	tended the above named nations and	that all the information supplied by me on this	
form is true and correct to the best of my	-	and an are information supplied by the off this	
Name of practitioner	Qualification(s)	Date	
Medical Practitioner's Signature (With Chop)	Specialty/Department/Unit (if from hospital)	Contact Number	