PRUDENTIAL BSN
TAKAFUL

PREGNANCY COMPLICATION CLAIM – DOCTOR'S STATEMENT

Note: This form is to be completed at the Patient's expenses by the Attending Doctor.

Patient's Personal Details

Name: ______________________ Certificate Number: ______________________

NRIC/Old IC/Passport/Birth Cert/Other: ______________________ Date of Birth: ______________________ Gender: ____ Male ____Female

The claim is being filled for the following illness: (Please tick [√] in the appropriate box)

Sections to be completed:		Sections to be completed:	
___ Abruptio Placentae	A, B & P	___ Ectopic Pregnancy	A, I & P
___ Acute Fatty Liver of Pregnancy	A, C & P	___ Gestational Diabetes Mellitus	A, J & P
___ Amniotic Fluid Embolism	A, D & P	___ Hydatidiform Mole	A, K & P
___ Death of Foetus	A, E & P	___ Late Miscarriage	A, L & P
___ Death of the Life Assured's Child	A, F & P	___ Postpartum Haemorrhage Requiring Hysterectomy	A, M & P
___ Disseminated Intravascular Coagulation	A, G & P	___ Pre-Eclampsia	A, N & P
___ Eclampsia	A, H & P	___ Pulmonary Embolism of Pregnancy	A, O & P

Note: Assessment of claims and provision of benefits will be based on the Certificate mentioned in the form.

SECTION A: Medical History of The Patient

1. Are you the patient's usual Medical Attendant?
   ___YES ___NO

2. Over what period do your record extend?
   a) First consultation ____Day _____Month _____Year
   b) Last consultation ____Day _____Month _____Year

3. What were the symptoms presented when you first attended the patient? How long has the patient been experiencing the symptoms when you first saw the patient?

Symptom(s)	Duration of Symptom(s)

4. Date when the patient first become aware of the condition(s).
   ____Day _____Month _____Year

5. Please advise what is the exact full diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

6. Date when the patient was informed of the diagnosis.
   ____Day _____Month _____Year

7. Name and the practice of doctor(s) who first diagnosed the patient.

8. Please provide the dates and other details of investigations performed.

Date (DD/MM/YYYY)	Test/Laboratory/Imaging

9. Is the diagnosis related to any of the following? (Please tick [√] and circle the relevant option)
   ___ Pregnancy resulting from fertility treatment, including in-vitro fertilization
   ___ Chosen to have a termination of pregnancy other than for medical reasons
   ___ Alcohol or Substance Abuse/Addiction
   ___ AIDS/HIV Positive
   ___ Violation of laws/Strike/Riots
   ___ Suicide/Self--inflicted injury or self-inflicted illness
   ___ Injuries or sickness arising from professional sports, racing of any kind, scuba-diving, aerial sport activities
   ___ Nuclear fusion, nuclear fission, nuclear waste or any radioactive or ionizing radiation
   ___ Psychological issue/Mental health disturbance/Nervousness/Sleeping disorder

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SECTION B: Abruptio Placentae

1. Does the patient have premature separation of the placenta from the uterine wall?
   ___YES ___NO

If Yes, is the above cause for the complications listed
   a) Fetal death ___YES ___NO
   b) Required emergency ___YES ___NO

SECTION C: Acute Fatty Liver of Pregnancy

1. Does the patient's abdominal ultrasound findings characterized by micro fascicular fatty infiltration of the liver?
   ___YES ___NO

2. Is the condition unique to pregnancy?
   ___YES ___NO

If No, please clarify the existing liver disease.

3. Does the patient have fulminant hepatic failure, defined as
   a) Acute onset of encephalopathy ___YES ___NO
   b) Within eight (8) weeks of diagnosis of liver ___YES ___NO
   c) No prior history of liver dysfunction ___YES ___NO

4. Was the diagnosis confirmed by an appropriate medical specialist and a liver biopsy?
   ___YES ___NO

5. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION D: Amniotic Fluid Embolism

1. Does the patient have amniotic fluid that enters blood circulation?
   ___YES ___NO

2. Does the condition has caused life threatening condition as listed below?
   a) Pulmonary oedema ___YES ___NO
   b) Cardiorespiratory arrest ___YES ___NO
   c) Coagulopathy (abnormal blood clotting) ___YES ___NO

SECTION E: Death of Fetus

1. Did the death of fetus occur prior to the complete delivery/expulsion/extraction from its mother?
   ___YES ___NO

2. Please state the number of weeks of gestation when the death of the fetus was first diagnosed.

3. Please provide details on how the death of fetus was confirmed.

4. Was the death of fetus due to the legal premature termination; or ending of a pregnancy or the result of a sudden unforeseen and fortuitous event;
   ___YES ___NO

SECTION F: Death of the Person Covered's child

1. When was the patient's child delivered?
   ____Day ______Month ______Year

2. When was the patient's child death?
   ____Day ______Month ______Year

3. Following the complete expulsion or extraction of the said child from its mother, was the child breathing or showing other evidence of life?
   ___YES ___NO

If Yes, please provide details of such findings.

SECTION G: Disseminated Intravascular Coagulation

1. Was there an event of over activation of the coagulation and fibrinolytic system during the pregnancy?
   ___YES ___NO
2. Please describe the details of the resulting microvascular thrombosis and major haemorrhage, if present.
3. Please clarify which month/week of pregnancy was Disseminated Intravascular Coagulation first diagnosed?
4. What was the treatment given?
5. Does the treatment mentioned above include lists below:
   a) Frozen plasma ___YES ___NO
   b) Unexplained coma ___YES ___NO
6. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION H: Eclampsia

1. Does the patient have signs and symptoms of pre-eclampsia?
   ___YES ___NO
2. Does the patient have the listed conditions below during pregnancy or shortly after delivery?
   a) Grand Mai seizure ___YES ___NO
   b) Unexplained coma ___YES ___NO

SECTION I: Ectopic Pregnancy

1. Please describe or provide the location where the implantation of a fertilized ovum had occurred outside the uterine cavity.
2. Please provide details on how the ectopic pregnancy was confirmed.
   Kindly furnish us with a copy of imaging/ultrasound results confirming the diagnosis.

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3. Was there any surgery performed to terminate the ectopic pregnancy?

___YES, kindly provide the date of surgery. _____Day _______ Month _______ Year

___ NO

The type of surgery performed was:

___Laparotomy

___Laparoscopic

Was the surgery:

___Emergency

___Elective

If No, what was the treatment?

4. What were the operative findings?
Kindly furnish us with a copy of the histopathology examination report.

SECTION J: Gestational Diabetes Mellitus

1. Did the patient have Diabetes Mellitus during pregnancy?

___YES ___NO

2. Please provide Oral Glucose Tolerance Test (OGTT) where venous plasma glucose 2 hours after 75g of oral glucose.

3. What was the treatment given?

4. Name of doctor and the specialty.

SECTION K: Hydatidiform Mole

1. Is the hydatidiform Mole at the end stage and degenerating?

___YES ___NO

2. Please provide details on how the Hydatidiform Mole, whereby the chorionic villi have formed vesicles that resembles a bunch of grapes, was confirmed.

Kindly furnish us with a copy if the histopathology examination report.

3. Is trophoblastic hyperplasia present and proven?

___YES ___NO

SECTION L: Late Miscarriage

1. Please clarify how the Late Miscarriage was diagnosed.
Kindly furnish us with a copy of the results confirming the diagnosis.

2. Please state the number of weeks of gestation for complete expulsion or extraction of the Life Assured’s fetus from the Life Assured.

3. Please provide details on how the death of fetus was confirmed.

SECTION M: Postpartum Haemorrhage Requiring Hysterectomy

1. Please clarify the cause of Postpartum Haemorrhage.
   ___Unresponsive and atonic uterus
   ___Ruptured uterus
   ___Large cervical laceration extending into the uterus
   ___None of the above, please specify

2. Was there any procedure/surgery performed for Postpartum Haemorrhage?
   ___YES, kindly provide the date of surgery. ____Day ______ Month ______ Year
   ___NO

3. Kindly specify the type of procedure/surgery done.

SECTION N: Pre-Eclampsia

1. Did the patient have pregnancy induced hypertension?
   ___YES ___NO

If Yes, kindly provide details of patient blood pressure reading & result of protein in urine.
Kindly furnish us with a copy of the test results confirming the diagnosis.

2. Please state the number of weeks of gestation when the patient first diagnosed with Pre-Eclampsia.

SECTION O: Pulmonary Embolism of Pregnancy

1. Did the patient have Pulmonary Embolism during pregnancy?
   ___YES ___NO

2. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION P: Attending Doctor's Declaration

I hereby certify that:
___ I am the patient's attending doctor and I have personally examined and treated the patient for the illness/injuries sustained; OR
___ I have personally perused the patient's medical records;
and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature :

Date :
Name :
Professional Qualification :
MMC/Registration Number :
Name & Address of Hospital/Clinic :
Official Stamp of the Hospital/Doctor :

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