YFLife
萬通保險

Supplement of Critical Illness & Total Disability Benefit Claim Form Part II-Heart Attack and Angioplasty

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 :

ID Card No. /Passport No. :

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1) Referring to the heart attack, please advise the severity of the suffering:
   a) Nature of the episode of the heart attack

   b) Date and duration of the acute symptoms

   c) Details of the presenting signs and symptoms

2) a) According to your record, was there any death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area?

   b) Was there any diagnostic test, especially **ECG & level of cardiac enzymes**, done for the patient? If so, please provide us the following details and please put a tick in the appropriate box as below: (please provide us with the report if any)

Date	Type of Test	Result / Diagnosis

   ☐ No ECG taken
   ☐ No elevation in cardiac enzyme levels

   c) Was there any significant ECG changes including ST segment depression of two millimeters or more?

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Name of Patient : _____ ID Card No. /Passport No. : _____

3) a) What type of surgery has been performed and when?

b) Please state the location and degree of stenosis of coronary arteries. (Please provide all report copy, if any) Please also indicate if angioplasty had been performed on that coronary arteries.

Location	Degree of stenosis	Angioplasty done (Yes/No)

c) Please provide the full name and address of the hospital where the operation took place.

4) Has the patient suffered from chest pain, hypertension, angina or other cardiovascular disease? If so, please advise details, especially the period of which the patient had such complaint(s):

Date / Period	Conditions	Diagnosis	Treatment(s)

5) According to your record, had you ever heard of this patient suffered from any major/chronic/congenital disease? If so, please elaborate.

6) Any other information to supplement the above?

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true and correct to the best of my knowledge and belief.

Name of practitioner	Qualification(s)	Date
Medical Practitioner's Signature (With Chop)	Specialty/Department/Unit (if from hospital)	Contact Number