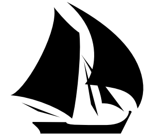
MELLITA CARE
ATTENDING PHYSICIAN STATEMENT

(TO BE COMPLETED BY THE ATTENDING PHYSICIAN)

Application Date

DD/MM/YY



Archipelago Life Insurance Limited (A Life Insurer Licensed by Labuan FSA)
Co. No. LL09829 Licence Bo. IS2013141

PATIENT'S DETAILS

Salutation : Mr / Mrs / Miss / Tan Sri / Dato' / Dr. / Ir. / (Others, pls state) :	
Full Name (Pls underline surname) :	
Date of Birth : DD/MM/YYYY	Gender : ☐ Male ☐ Female
NRIC / Valid Passport No :	Age :
Address :	
	Postal Code :
Contact No :	

PHYSICIAN'S DETAILS

Title :	
Full Name :	
Hospital/ Medical Centre:	
Address :	
	Postal Code :
Contact No :	Email :

1	**Weight :** Kg	**Height :** cm		
2	Which year was diabetes diagnosed?	DD / MM / YYYY		
3	What type of diabetes? : • Insulin-dependent (Type I) • Non-insulin-dependent (Type II)	 ☐ Yes ☐ Yes	 ☐ No ☐ No	
4	Treatment: • Oral hypoglycemic medication	☐ Yes	☐ No	If yes, please specify :
	• Insulin	☐ Yes	☐ No	If yes, number of injections per day :
5	Has the Patient already been hospitalised for diabetes or any complications caused by diabetes (without taking into account the initial treatment)	☐ Yes	☐ No	If yes, when? [give date(s)] : Precise motives :

6	Is the patient a smoker? • Cigarette smoker • Pipe or cigar smoker • Former smoker • Has never smoked	 ☐ Yes ☐ Yes ☐ Yes ☐ Yes	 ☐ No ☐ No ☐ No ☐ No	Number of cigarettes per day : Started smoking : (age) Stopped for : years
7	Is the patient being treated for : • Hypercholesterolaemia • Hypertention • Other (s)	 ☐ Yes ☐ Yes ☐ Yes	 ☐ No ☐ No ☐ No	If yes, specify treatments :
8	Follow-up of diabetes : • Attending Physician • Medical Specialist • Self-testing	 ☐ Yes ☐ Yes ☐ Yes	 ☐ No ☐ No ☐ No	Frequency of visits / year : Average number of tests / day :

9

ADDITIONAL EXAMINATIONS : Specify the following biological parameters :
(Only the results of examinations carried out in the last 12 months are taken into account)

	1	2	3
Dates	Current	DD / MM / YYYY	DD / MM / YYYY
Glycated Haemoglobin Level (Hba1c) ☐ % ☐ Mmol/L			
Laboratory normal values ☐ mg/dL ☐ Mmol/L			
Fasting blood glucose levels ☐ mg/dL ☐ Mmol/L			

10

Hyperlopidemia

Specify date(s) and result(s) : ☐ mg/dL ☐ mmol/L ☐ g/L

Total Cholesterol :	HDL-Cholesterol :
Triglycerides :	LDL-Cholesterol :
Serum Creatinine :	

11

Blood Pressure

	Systolic BP	**Diastolic BP**
1st Reading	mmHg	mmHg
2nd Reading	mmHg	mmHg
3rd Reading	mmHg	mmHg

12	**Other examinations :** • MIcro Albuminuria or Proteinuria • Funduscopy / Fluorescein angiography • ECG / Stress Test / Doppler / Coronarography :	 ☐ Yes ☐ Yes ☐ Yes	 ☐ No ☐ No ☐ No	Please specify dates and results : Laboratory normal values :

13	Are there any diabetes related complications : • Cardiovascular (Arteritis, Coronary Failure, Infarction, Cerebrovascular, Others)? • Ocular? • Nervous? • Renal? • Gangrene, Perforating Ulcer, Amputation due to Diabetes? • Sick leave due to diabetes or any diabetes related complications lasting for more than two weeks in the past 5 years?	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No ☐ No ☐ No	If yes, specify : If yes, give date(s) and motive(s) :
14	Additional Information : • Depression, Anxiety, Stress, Eating Disorder or any other Psychological disorder? • Varicose veins or venous ulcers? • Disease or disorders of the prostate, urinary system, kidney or bladder? • Have any of your immediate family members (father, mother, sister, brothers) ever suffered from or died as a result of diabetes, heart diseases, stroke, cancer or any hereditary disease before age of 60 years? • Is there any other information or exceptional circumstance pertaining to your health not disclosed above and which would be material to the acceptance of this application? • Experience any end organ damage: Left Ventricular hypertrophy, Hypertensive, Nephropathy, Hypertensive Retinopathy, Retinopathy, Neuropathy, Nephropathy? • Medical emergency due to Diabetes? • Has any foot been infected due to Diabetes? • Has any eye been affected due to Diabetes?	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No	If yes, please specify : If yes, give date(s) :

I/We confirm that information give here is correct and complete and this medical report(s)/ statement(s) is/are to be used by Archipelago Life Insurance Limited for their underwriting purpose.

Signature of the Attending Physician

Date : DD / MM / YYYY

Stamp

RELEASE CONSENT OF MEDICAL REPORT(S)/ STATEMENT(S) TO ARCHIPELAGO LIFE INSURANCE LIMITED

I/ We confirm that my/our Attending Physician’s Medical Report(s) / Statement(s) can be released to Archipelago Life Insurance Limited for their underwriting purpose.

Signature of Patient

Date : DD / MM / YYYY

Archipelago Life Insurance Limited

Co. No. LL09829 I Licence No. IS2013141

Registered Office Address:

Brumby Centre, Lot 42, Jalan Muhibbah, 87000 Labuan Federal Territories, Malaysia.

Co-located Office:

B-08-07, Gateway Corporate Suites, Gateway Kiaramas, No.1 Jalan Desa Kiara, Mont Kiara, 50480 Kuala Lumpur, Malaysia

Telephone : +6 (03) 6201 0491
Fax : +6 (03) 6201 0481
Email : customerservice@archipelagolife.com
URL : www.archipelagolife.com