Olé

MEDICAL REPORT ON TERMINAL ILLNESS CLAIM

Dear Doctor,

Your patient holds a life insurance policy which provides a benefit if he/she is **suffering from a terminal illness AND his/her life expectancy is less than 12 months.**

In order to evaluate this claim, we ask you to provide a report in relation to this patient's illness and prognosis, including the answers to the following questions:

Patient's Name: ______________________________

Identification Number: ______________________________ Date of Birth: dd / mm / yy

1. Provide definite diagnosis, comorbidities and complications: ______________________________

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2. Date of Diagnosis: dd / mm / yy

3. Describe which symptoms were present initially and their duration:

SYMPTOMS	ONSET DATE	DURATION OF SYMPTOMS

4. Please list dates and results of tests/ investigations for this condition:

SYMPTOMS	ONSET DATE	DURATION OF SYMPTOMS

5. Please confirm the site(s)/organ(s) affected and severity of the illness: ____

6. Please confirm histology and staging and provide a copy of all pathology reports: ____

7. Indicate if your patient is a smoker and if abuses of any substance and if so, please explain what type, how many per day and for how long: ____

8. Has this patient previously suffered from the same condition or a related condition?
If yes, please explain: **YES** ◯ **NO** ◯ ____

9. Is there a family history of this disease? **YES** ◯ **NO** ◯
If yes, please explain: ____

10. How is the current medical condition of the patient? ____

11. Is there a driver mutation amenable to targeted treatment? (Please give details) ____

12. Please give details of current treatment: ____

13. What has been the patient's response to treatment? ______________________________

14. Have all treatment options now been exhausted? **YES** ◯ **NO** ◯

15. What are the future treatment plans and what is the goal of such treatment? ______________

16. Are there any risk factors that will affect prognosis? **YES** ◯ **NO** ◯
If yes, please give details: ______________________________

17. What is the prognosis in your opinion? ______________________________

18. In your opinion is their life expectancy less than 12 months? **YES** ◯ **NO** ◯
Please explain the reason(s) for/basis of your opinion: ______________________________

19. Is there any other information which would be helpful to us in assessing this patient's claim?

DOCTOR'S INFORMATION

Full Name:______________________ ID number:______________________

Email:______________________ Professional license number:______________________

Office Phone Number:______________________ WhatsApp Number:______________________

As an authorized treating physician, I authorize all hospitals where the insured was treated to grant Olé Insurance Group Corp. I.I. all reports that refer to the insured, including all data of previous conditions. Under oath to tell the truth, I declare that the information provided in this form is correct and true and I understand that anyone who submits false or inaccurate information is guilty of crime and subject to the corresponding sanctions.

Doctor's signature:______________________ Date: dd / mm / yy

Please include the following documents:

1. Copy of reports of all medical exams performed since the date of the original diagnosis.
2. Copy of the office notes of all visits since the date of the original diagnosis.
3. Name and contact information of any other physician who participated in the care of this patient.