

Enter information in either English or Japanese.
 ※日本語で証明が可能な場合は、日本語で証明をお願いいたします。

To Daiichi Life (第一生命あて)

<海外用>

NOTE: If you make any corrections, please write your signature as proof.

ATTENDING PHYSICIAN'S STATEMENT (入院証明書兼診断書)			
Patient's name (患者氏名)		<input type="checkbox"/> Male (男) <input type="checkbox"/> Female (女)	Patient's date of birth (生年月日)
Clinical record card No (カルテ番号)			(M) / (D) / (Y)
Name of sickness or injury for hospitalization (入院の原因となった傷病名)		Inception date of sickness or injury (Physician's estimate) (医師推定 傷病発生年月日)	
		(M) / (D) / (Y)	
Cause of above sickness or injury (上記の原因)		Inception date of sickness or injury (Physician's estimate) (医師推定 傷病発生年月日)	
		(M) / (D) / (Y)	
Previous sickness (If any) (既往症)	Name of illness, treatment term and any other pertinent information (病名・治療期間等)	Was the patient introduced or previously seen by another physician? (If any) (前医・紹介医)	Name of physician (医師名) Name of medical institution (医療機関名)
Treatment term (治療期間)	First medical Consultation (初診)	(M) / (D) / (Y)	
		Date admitted (入院)	Date discharged (退院)
	1st hospitalization (第1回目入院)	(M) / (D) / (Y)	(M) / (D) / (Y)
	2nd hospitalization (第2回目入院)	(M) / (D) / (Y)	(M) / (D) / (Y)
Reason for hospitalization (入院の契機) Please check either one of the boxes below. <input type="checkbox"/> (1) Patient's request (患者希望) <input type="checkbox"/> (2) Physician's instructions (医師の指示)		Payment of the patient's hospitalization costs (入院の費用) Please check either one of the boxes below <input type="checkbox"/> (1) Coverage under the public health insurance system (公的医療保険の適用) <input type="checkbox"/> (2) Out-of-pocket expense (not covered by public health insurance) (自費) ※If (2), please answer the next question (3). (3) Was the hospitalization significant enough to be covered by public health insurance? Please check either Yes or No <input type="checkbox"/> Yes / <input type="checkbox"/> No	
Condition of sickness from when you first noticed the symptoms to the first medical consultation (発病から初診までの経過) (Please indicate when and how the symptoms first appeared) (いつ頃からどのような症状があったか記入してください)			
Diagnosis at the time of first consultation and progress thereafter (初診時の所見及び経過) (Please give details of the examination and treatment) (検査・治療状況の詳細)			
Type of surgery. Please check either one of the boxes below. (手術の種類: 開頭/開胸/開腹/ファイバースコープまたはカテーテルの手術/その他) <input type="checkbox"/> (1) Craniotomy <input type="checkbox"/> (2) Thoracotomy <input type="checkbox"/> (3) Laparotomy <input type="checkbox"/> (4) Surgery using a fiberscope or catheter <input type="checkbox"/> (5) Other			
Name of surgery or operation Include percutaneous surgery (TAE etc.), drainage, shunting (手術名/経皮的手術経カテーテル動脈塞栓術等、ドレナージ、シャント含む)		Date of surgery (手術日)	
		(M) / (D) / (Y)	
Radiotherapy (if any) (根治放射線照射)	Region (部位)	Period (期間)	Quantity in total (総線量) Gy
		(M) / (D) / (Y) ~ (M) / (D) / (Y)	
In case of Malignant Neoplasms / Intraepithelial Neoplasia (悪性腫瘍/上皮内腫瘍の場合)	Name of histopathological diagnosis (or ICD-O Morphology codes) (病理組織診断名(または ICD-O コード))		
	Date of diagnosis (診断確定日)	For neoplasms. Please check either one of the boxes below. (腫瘍の種類)	
	(M) / (D) / (Y)	<input type="checkbox"/> (1) Carcinoma in situ, Noninvasive <input type="checkbox"/> (2) Invasive carcinoma	
The date when the diagnosis was informed (診断名が通知された日 患者に/家族に どういう診断名を伝えたか) to the patient (M D Y) as having () to the family (M D Y) as having ()			
The statements contained above are true and complete to the best of my knowledge and belief. (上記のとおり証明します)			
Name of hospital/medical department (病院名/診療科)		Date	
Address of hospital/Contact phone number (病院住所/電話番号)		(M) / (D) / (Y)	Signature of attending physician (主治医の署名)

Notes regarding the filling in of medical certificates (In case of Malignant Neoplasms / Intraepithelial Neoplasia)

DAI-ICHI LIFE

<How Critical Illness Insurance works>

If the patient gets Critical Illness Insurance, an insurance payment is made in any of the following cases:

① The insured person is diagnosed as having a malignant neoplasm; ②The insured person suffers an acute myocardial infarction and then remains in a certain designated condition for at least a certain designated time; ③The insured person suffers cerebral apoplexy and then remains in a certain designated condition for at least a certain designated time

★ The definition of malignant neoplasm reimbursed by Critical Illness Insurance (the contract)

●The neoplasm reimbursed by the insurance here means the disease which shows the existence of malignant neoplasm cells and the invasive/destructive increase of the malignant cells.

●Depending on the type of insurance the patient gets, the exceptions are as follows:

1. Carcinoma in situ (including melanoma in situ)
2. Skin cancer (excluding malignant melanoma)

< The notice when you describe the part of “In case of Malignant Neoplasms / Intraepithelial Neoplasia ” in this attending physician's statement >

1.The diagnosis which was confirmed by the biopsy and so on should be described in the

“Name of histopathological diagnosis (or ICD-O Morphology codes)”

2.In situ cancer means the invasion of malignant cells are limited in epithelium and neither invade nor destroy the submembrane area which divides epithelium and connective tissues: in this case, please check “(1) Carcinoma in situ, Noninvasive”.

When the malignant cells invade submembrane area , please check “(2) Invasive carcinoma”.