Medical Certificate (Colon polyps) for Hospitalization / Surgery

To: NIPPON LIFE INSURANCE COMPANY

ATTENDING PHYSICIAN'S STATEMENT OF HOSPITALIZATION / SURGERY

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Please mark (with a circle) one of the dotted options.

1. Patient's Name — Chart No. ( ) | **Sex** Male / Female | **Date of Birth** month / day / year

2. Name of Disease / Injury — 1. Colon polyps | 2. Other ( )

3. Date of Initial Consultation — month / day / year

4. Outpatient Surgery Possible — 1. YES | 2. NO

5. Reason for Hospitalization — 1.Patient's Request | 2.Doctor's Recommendation → If "Doctor's Recommendation," please indicate

6. Medical Basis for Hospitalization

7. Symptoms on Admission (*Multiple options allowed) — 1.None | 2. Abdominal pain | 3. Fever | 4.Vomiting | 5.Diarrhea | 6.Hematemesis | 7. Rectal bleeding

8. Tests on Admission (*Multiple options allowed) — 1.None | 2.Blood test | 3. Abdominal ultrasound | 4.Upper GI endoscopy | 5.Lower GI endoscopy | 6. X-ray | 7. CT scan | 8.Other ( )

9. Period of Hospitalization

1st from month / day / 20 year ~ till month / day / 20 year — 1. Discharged (including Transfer to Another Hospital) | 2.Died during Hospitalization | 3. Currently Hospitalized | 4.Transfer to Another Department

2nd from month / day / 20 year ~ till month / day / 20 year — 1. Discharged (including Transfer to Another Hospital) | 2.Died during Hospitalization | 3. Currently Hospitalized | 4.Transfer to Another Department

If there are three or more hospitalizations, please indicate admission and discharge dates. (If currently hospitalized, note "Currently hospitalized.")

10. (For hospitalization only) Does this hospitalization qualify as admission for diagnostic purposes? — 1.YES | 2.NO

11. Surgery Performed for Disease / Injury in Section 2 Above (Including Continuous Drainage / Ethanol Injection Therapy)

Surgery

Name of surgery	(1. Left / 2. Right / 3.Bilateral)	Date of surgery
	1. Left / 2. Right / 3.Bilateral	month / day / 20 year
	1. Left / 2. Right / 3.Bilateral	month / day / 20 year

Remarks — If other surgeries were performed, please indicate the surgery procedure name and date.

12. In Cases of Malignant /In Situ Neoplasm

Does the patient have a history of malignant/in situ neoplasm prior to the current condition? (1.Yes / 2.No) ⇒ *If "Yes," indicate "disease name" and "time of diagnosis" below. (Approximate date) [Disease Name] [Time of Diagnosis] month / year

Date of Definitive Diagnosis: month / day / year

Has the patient been informed of the malignant diagnosis? (1.Yes / 2.No) If "Yes," date informed : month / day / year

Classification of the Current Malignant (In Situ) Neoplasm: 1.Primary / 2.Recurrent / 3.Metastatic

Pathological Diagnosis

1.Yes — Histopathologic Diagnosis Nama [ ] (1. Invasive carcinoma / 2. Noninvasive carcinoma / carcinoma in situ) Histological depth of invasion (1. Beyond SM / 2.M) cTNM Staging T ( ) N ( ) M ( )

2.No * — * If "Yes," leave the table below blank.

Diagnostic Methods and Summary of Results (Multiple checked options and answers allowed)

Option	Method	Summary of Results
☐	Cytology	
☐	CT / MRI	
☐	Angiography	
☐	Other ( )	

Treatment History and Future Treatment Plan (Multiple checks and answers allowed)

	Treatment History	Future Treatment
Surgery	☐	☐
Chemotherapy	☐	☐
Radiation therapy	☐	☐
Palliative care	☐	☐
Other ( )	☐	☐

13. Treatment Received as Outpatient

Year / Month of Outpatient Visit	Total days	Please circle the dates of outpatient treatment for the disease/ injury in Section 2 above following discharge. (Including home visits and excluding scheduled appointment dates.)
year month	days	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
year month	days	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
year month	days	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

14. Prior Medical Care — 1. YES / 2. NO — Medical Institution Name: (Treatment Period) From / To / (approximate dates)

15. Mental Capacity — If the patient cannot understand the meaning of claiming and receiving insurance money/ benefits, mark with a circle. Unable

I hereby certify that the above information is true and complete to the best of my knowledge.

Medical Institution

Institution Name :
Address :
Department :
Phone Number :
Physician's Name :
Country :

Date of Certification: month / day / year

(Signature)