INITIAL CLAIM FORM
TRAUMA

Issued 1 March 2019

We wish to make the lodgement of your claim as easy as possible. Please note the points below. These are important in ensuring we make an accurate assessment.

- Pages 1-11 are to be fully completed by you, pages 13-16 are to be fully completed by your usual general practitioner and pages 17-20 by your treating specialist.
- If you run out of room please note the Additional Information section. Please note the reference number of the question you are supplying additional information if relevant.
- Please complete all sections of the first part of the form.
- An incomplete claim form may delay assessment of your claim.
- If there is insufficient space to adequately answer any question, please attach additional pages.

Please note issuing of this claim form is not an admission of liability.

If you have any questions or require assistance with the completion of this form, please do not hesitate to call us on 1800 024 812.

A. Life insured details Please use block letters

Policy number: LFAE 303 7555

Title: Mr ☐ Mrs ☐ Miss ☒ Ms ☐ Other ☐ Please specify

Surname: JENKINS

Given name(s): JESSICA MARY

Date of birth: 27/07/81 Height: 163 cm Weight: 86 kg

Occupation: HR + Services Manager

Home address: 2 Cycas Street

ARANA HILLS State: QLD Postcode: 4054

Telephone: Home ( ) n/a Work (07) 32105308 Mobile 0404 678 736

Postal address: as above

State Postcode

Business address: n/a

State Postcode

ABN (if applicable): n/a Business telephone ( )

B. Policy owner details (if different to the life insured)

Policy number

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ Please specify

Surname

Given name(s)

Home address

State Postcode

Telephone: Home ( ) Work ( ) Mobile

Postal address

State Postcode

Business address

State Postcode

ABN (if applicable) Business telephone ( )

C. Claim details

1. Please give details of your condition and the area affected (please refer to the insured event in your policy document for the definition of the eligible condition to be claimed).

Non-Hodgkin Lymphoma - lymph nodes, spleen, bone, bone marrow.
(Diffuse Large B-Cell Lymphoma).
Chemotherapy (R-chop) treatment commenced 24/12/2019

2. Please advise of the date of the first onset of symptoms. 15/11/2019

Description of onset of symptoms.

Enlarged inguinal lymph node (left).
Dr consulted Sunday 17/11/2019 (after hours dr - Dr Neal Hearnden, Arana Medical).

3. a. Please give details of your usual general practitioner and the date of your consultations.

Name: Dr Ross Bourne, Arana Medical Centre.
Address: Kmart Plaza, Patricks Rd, Arana Hills
07 3351 6444 State: QLD Postcode: 4054

Date of first consultation: 25/11/19 Date of latest consultation: 9/12/19

b. Please give details of the specialist(s) you have consulted for your current condition.

Name	Type of specialist	Address	Phone no.	Date of first consultation	Date of last consultation
Dr. Jason Butler	Hematologist	RNBH.		6/12/19	10/10/2020
QScan	Ultrasound	Everton Park		20/11/19	/ /
QScan	FN Aspiration	Red Hill		29/11/19	/ /
QScan	Core Biopsy	Red Hill		5/12/19	/ /
	Bone Biopsy	RNBH		19/12/19	/ /

c. Please give details of any other doctors/health care professionals you have consulted for this condition.

Name	Type of doctor	Address	Phone no.	Date of first consultation	Date of last consultation
RNBH	PET Scan			10/12/19	/ /
RNBH	ECG			18/12/19	/ /
				/ /	/ /
				/ /	/ /
				/ /	/ /

D. Medical details

1. If you were admitted to hospital at any stage for this condition please provide details in the table below:

Period in hospital	Name and address of hospital	Reason for hospitalisation
/ / to / /		
/ / to / /		
/ / to / /		
/ / to / /		

2. Was an operation performed on any of these periods in hospital? ..... Yes ☐ No ☒
   If 'yes':

Date performed	Type of operation	Name of surgeon
/ /		
/ /		
/ /		
/ /		

3. a. Did you cease working due to your condition? ..... Yes ☐ No ☒
   If 'yes', please provide the date you ceased all work. ..... / /
   b. Are you currently still off work? ..... Yes ☐ No ☒
   If 'no' please provide the date you returned to work. ..... / /

4. Have you ever suffered from this condition previously? ..... Yes ☐ No ☒
   If 'yes', please provide details.

5. Did you consult a doctor for this condition previously? ..... Yes ☐ No ☒
   If 'yes', please provide details.

Name	Type of doctor	Address	Phone no.	Date of first consultation	Date of last consultation
				/ /	/ /
				/ /	/ /
				/ /	/ /
				/ /	/ /
				/ /	/ /
				/ /	/ /

E. Other details

1. a. Do you have any other life insurance, similar benefits with any other life insurance company or a superannuation fund?....Yes ☒ No ☐

If 'yes', please provide details.

Company/fund	Date cover commenced	$ Amount	Type of benefit
Australian Super	29 / 12 / 2007	$ 47,000	life / tpd
	29 / 12 / 2007	$171,000	death
	29 / 12 / 2007	$268,639	balance super
	/ /		
	/ /		

b. Have you claimed on the above mentioned life insurance? .....Yes ☐ No ☑

If 'yes', please provide details.

Date lodged / /

Insurer's name

Address

State Postcode

Telephone

Claim no.

Case manager

c. Claim denied: .....Yes ☐ No ☐

If 'yes', please give reasons.

d. Claim accepted: .....Yes ☐ No ☐

If 'yes', please provide details.

Date accepted / /

Insured benefit $

Date of settlement / /

Settlement amount (if applicable) $

Additional information

Additional information (continued)

Information to representative

Privacy legislation restricts the information we can provide to your representatives in respect of your claim. If you want a family member, friend or financial adviser to be able to obtain information about your claim please provide their details below.

I consent to Asteron Life & Superannuation Limited (Asteron) disclosing personal information about my claim to the specific people listed below. I understand that this information may include details about my health, occupation, financial situation, lifestyle and insurance.

Name

Date of birth / /

Relationship to me

Name

Date of birth / /

Relationship to me

Financial Adviser's Name

Financial Adviser's Business Name

Nomination of guardian/representative (Please complete this nomination section only if applicable)

I hereby declare that _____ (Insert nominated guardian's/representative's name) is nominated as my guardian/representative for all aspects of my claim I give permission and consent for all decisions to be made by my nominated guardian/representative.

Power of Attorney has been granted to the above mentioned guardian/representative. ..... Yes ☐ No ☐

If 'yes', date issued: ..... / /

I attach a copy of the endorsed Power of Attorney.

If 'no', I attach a verified copy of my nominated guardian's/representative's passport/driver's licence for identification.

Signature of Life Insured X _____ Date 10/01/2020

Declaration and authority

I declare that the answers and statements made on this claim form are true and complete. I have not made any false or misleading statements. If any of the answers are not in my handwriting, they have been checked by me and are correct.

I confirm that, before or at the time I provided any personal information, I have read and understood the Privacy Statement which has been provided to me with this form. The Statement is also available on the web site at www.asteronlife.com.au/privacy.

I consent to the Asteron Life & Superannuation Limited ABN 87 073 979 530, AFSL 229880 (Asteron) collecting, using and disclosing my personal information, including sensitive information, in accordance with the Statement, including for the purpose of assessing my claim.

I authorise Asteron or any person duly authorised by Asteron to disclose my personal information (which may include sensitive health information) to the parties referred to in the Statement some of which are included in the medical and information authorities below.

Medical authority

I authorise any doctor, hospital or any other health care provider who has attended or examined me to supply Asteron, or its representatives, with full particulars of my medical history, consultations, prescriptions or treatment, including copies of all hospital or medical records, referral letters, reports and details of any clinical notes that have been made.

Information authority

I authorise any adviser/broker, claims assessor, financial or professional institution, independent medical assessor, insurer or reinsurer, insurance reference service, investigator, legal and accounting firm, auditor, employer, trustee or consultant to supply Asteron, or its representatives, personal information about me which Asteron, reasonably requests for the purpose of assessing my claim.

I further consent to these parties releasing information about me to Asteron. This information may include but is not limited to information about my sickness or injury.

I agree that a photocopy (or similar copy) of this authorisation shall be as effective and valid as the original.

I understand:

- I am responsible for any expenses incurred with the gathering of information for this claim form, including medical reports or test results
- if I do not give the information requested, my claim may not be reviewed, and therefore my claim may not be payable
- if I make any false or fraudulent statements that the Asteron may refuse to pay and/or cancel my claim.

Signature of Life Insured: X [signature] Date 10 / 01 / 2020

Name of Life Insured (please print): JESSICA JENKINS

Signature of Policy Owner (if different): X Date / /

Name of Policy Owner (please print):

PAYMENT DETAILS:

To be completed by the policy owner.

If the claim is accepted, payment will be made to the Policy Owner. Please note that the Policy Owner may be different to the Life Insured.

☐ Please issue a Cheque to the Policy Owner

☑ Please arrange a Direct Credit to the Policy Owner's bank account as follows:

Bank Name: Bankwest Branch Location:

Account Name: Jessica Mary Jenkins BSB Number: 304 - 260

Account Number: 010 9369 Please note this does not include Credit Card Accounts

Authorisation of Policy Owner(s): X [signature] X

Please print name of Policy Owner(s): Jessica Jenkins

Information authority

GPO Box 134, Sydney NSW 2001

Freecall 1800 024 812 | Facsimile 1300 766 773 | Web www.asteronlife.com.au

Asteron Life and Superannuation Limited ABN 87 073 979 530 AFS Licence No 229880

Checklist

TRAUMA

Have you:

1. Signed and dated the Declaration and authority..... Yes ☑
2. Signed and dated the Nomination of guardian/representative (only if applicable)..... Yes ☑
3. Life Insured claim form – ensured you have completed each question in detail ..... Yes ☐
4. General Practitioner's Statement – ensured your doctor has completed this section of the claim form..... Yes ☑
5. Treating Specialist's Statement – ensured your doctor has completed this section of the claim form ..... Yes ☑
6. Attached your original policy document and original policy schedule. ..... Stat dec attached ..... Yes ☐ ✗
7. Attached a certified copy of your proof of age (passport, driver's licence, birth certificate) ..... Yes ☑
8. Attached copies of medical investigation reports (e.g. scans, x-rays, blood tests, histopathology report)..... Yes ☑

If you have answered 'yes' to all of the above please forward this documentation to:

Asteron Life Claims
GPO Box 134
Sydney NSW 2001

If you require any assistance please contact us on our free call number 1800 024 812.

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ACCEPTABLE PROOF OF IDENTITY CERTIFIER

Issued 1 March 2019

Acceptable certifiers are listed below and must not be:

- The Life Insured or Policy Owner
- A Business Partner of the Life Insured or Policy Owner
- Any member of the family of the Life Insured or Policy Owner
- The Life Insured or Policy Owner's Financial Adviser

Australia Post employees

An agent of Australia Post who is in charge of an office supplying postal services to the public; or a permanent employee of Australia Post with two or more years of continuous service who is employed in an office supplying postal services to the public

Banking & other financial institutions

An officer with two or more continuous years of service with one or more financial institutions or a finance company officer with two or more continuous years of service with one or more financial companies

JP or Notary Public

An individual appointed by the courts whose duties include certifying documents

Legal professionals / law enforcement

A person who is enrolled on the roll of the Supreme Court of a State or Territory, or High Court of Australia, as a legal practitioner. Other professionals include a judge of a court; a magistrate; a chief executive officer of a Commonwealth court; a registrar or deputy registrar of a court or a police officer

Accountant

A member of the institute of Chartered Accountants in Australia, CPA Australia or the National Institute of Accountants with two or more years of continuous membership

Australian consular or diplomat office

An Australian consular officer or an Australian diplomatic officer

Any queries please contact Life Customer Service on 1800 024 812 or e-mail life_claims@asteronlife.com.au

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LOST/DESTROYED POLICY STATUTORY DECLARATION

Issued 1 March 2019

Name of policy owner: Jessica Mary Jenkins

Policy number: LFAE 303 7555

Address: 2 Cycas Street
Arana Hills, 4054

I, (Print Name) Jessica Mary Jenkins

Address 2 Cycas Street, Arana Hills, QLD 4054

Occupation HR + Services Manager

declare in my capacity as Policy Owner

(eg. Executor, policy owner, policy beneficiary) that:

1. I have made a claim under the Asteron Life & Superannuation Limited (Asteron) policy and declare that the policy has been destroyed or is lost, and that a diligent search has been made for it without it being found.
2. To the best of my knowledge and belief the policy has not been lodged for safekeeping with any person.
3. To the best of my knowledge and belief the policy has not been transferred, assigned, lodged for security or otherwise deposited, charged or dealt with, nor has the policy been disposed of by me, nor have the benefits been paid nor my interest therein been transferred to any other person/s.
4. I undertake that I will deliver the policy or any previously issued replacement policies to Asteron if found.
5. In consideration of the payment of the Policy proceeds without production of the policy I undertake to indemnify and keep Asteron indemnified against any claims in respect of the policy, or the issue of the replacement policy.

I understand that a person who intentionally makes a false statement in a statutory declaration is committing an offence under section 11 of the Statutory Declarations Act 1959, the punishment for which is imprisonment for a term of four years. Chapter 2 of the Criminal Code applied to all offences against the Statutory Declarations Act 1959. I believe the statements in this declaration are true in every particular.

Signature of claimant X [signature] Date 07 / 01 / 2020

(Please return this with $50.00 payment payable to Asteron Life & Superannuation Limited)

Declared before me (signature of person before whom the declaration is made):

X [signature]

Full name, qualification and address of person before whom the declaration is made (in printed letters)

(Print Name) Katie Louise Jacklin

Qualification Manager

Address 22 Cordelia St
Southbrisbane QLD 4000

The list of people who can witness the declaration include a full-time school teacher, justice of the peace, doctor, pharmacist, or legal practitioner. For a full list of people able to witness this document, please contact 1800 024 812.

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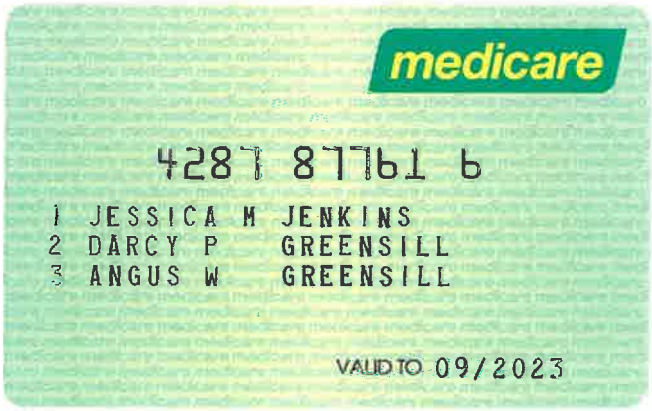

Certified to be a true copy of the original seen by me on 7 January 2022 in Brisbane.

Katie Jackelan
Lawyer.
22 Cordelia St, South Brisbane
QLD 4000

GENERAL PRACTITIONER'S STATEMENT INITIAL CLAIM FORM TRAUMA

Issued 1 March 2019

We value your feedback as the treating doctor and we seek your independence in completing this form.

We understand this form may take some time initially but in the long term will reduce the amount of queries to yourself and your patient. This will allow for a speedier assessment and greater understanding of the claim

Please note if there is a charge for completion of this form, it is the responsibility of your patient.

If you have any queries do not hesitate to contact us on 1800 024 812.

This form is to be completed by your usual general practitioner

Please use block letters

1. Insured's name: Jessica Mary Jenkins
   Date of birth: 27/07/1981
2. Are you the Insured's usual general practitioner? ..... Yes ☑ No ☐
3. a. Please provide the date since the Insured has been your patient or a patient of your practice 17/05/17
   b. Please provide the first date the Insured consulted you for the current condition 17/11/2019
4. a. Please advise of your current diagnosis for the Insured.

Diffuse large B-cell lymphoma stage 3

b. Date of diagnosis 2/12/19

c. What investigations were carried out to support your diagnosis?

Dates	Description	Result
20/11/19	USS left groin	pathological nodes
29/11/19	FNA biopsy	likely lymphoma
5/12/19	core biopsy	Defined lymphoma subtype
/ /		

d. Please provide details of symptoms as follows:

Symptoms leading to diagnosis

Left inguinal mass noted by patient
some night sweats

e. Duration of symptoms

from early Nov 2019

f. Current symptoms

on chemotherapy causing fatigue, possible hair loss mucositis, bone marrow suppression going forward

5. Have the Insured ever had the same or similar condition? ..... Yes ☐ No ☑

If 'yes', please provide the date and details. ..... / /

6. Is there a family history with regard to this condition? ..... Yes ☐ No ☑

If 'yes', please provide details.

Family member (Relationship to insured)	Condition/sickness	Age at onset (Approx)	Age at death (If applicable)

7. Please advise if there is a history of contributing factors leading to the connection or causation of the Insured's condition (e.g. health or lifestyle factors):

ND

Additional information

Please provide your details below and we thank you for completing this form.

I hereby declare that the above statements are true and correct.

Signed [signature] Date 03 / 01 / 2019

Name Dr. Ross Bourne

Qualifications B.Med.Sci. MD (Griffith)

Address Provider No: 5077117X
Arana Hills Medical Centre
Arana Hills Plaza, Patricks Rd, Arana Hills Q4054
Phone: (07) 3351 6444 Fax: (07) 3351 6246

State Postcode

Telephone ( ) Fax ( )

Email rossbourne713@gmail.com

Please attach copies of all tests/investigations.

8. What is the general medical history? (Please attach a separate page should you not have enough space, or you may wish to provide a copy of your clinical notes.)

Date of consultation	Diagnosis
11 / 12 / 18	Depression
4 / 10 / 19	chronic urticaria
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9. Any additional comments that may assist us in assessing this claim.

Please complete the declaration overleaf.

Jenkins , Jessica
2 Cycas Street ARANA HILLS 4054
Phone: 0404678736

Birthdate:	27/07/1981	**Sex:**	F	**Medicare Number:**	42878776161
Your Reference:	DR=0263331F	**Lab Reference:**	2019E0023501-1		
Laboratory:	QSCAN Radiology				
Addressee:	NEIL HEARNDEN	**Referred by:**	NEIL HEARNDEN		
Name of test:	Ultrasound Left Groin				
Requested	20/11/2019	**Collected:**	20/11/2019	**Reported:**	20/11/2019 16:19:00

Qscan
RADIOLOGY CLINICS

Ultrasound Left Groin

Patient:	JENKINS, JESSICA	**Date of Birth:**	1981-07-27	**Sex:**	F
Address:		**Medicare Number:**		**Phone:**	CP 0404678736
Sender:	WOOD, Dr Tanya	**Addressee:**	HEARNDEN, Dr Neil	**Referred by:**	Dr Neil Hearnden
Lab Reference:	2019E0023501-1				
Requested:		**Collected:**	20/11/2019 2:36:00 PM	**Reported:**	20/11/2019 4:19:00 PM

ULTRASOUND LEFT GROIN

History
Lump left inguinal region, lymph node versus hernia

Findings
Multiple lymph nodes are demonstrated both within the left iliac fossa and also within the inguinal region.

Within the left iliac fossa, there is an abnormally appearing and enlarged lymph node that measures 27 x 33 x 23 mm.

Within the left inguinal region, there is a further abnormally appearing and enlarged lymph node that measures 25 x 17 x 19 mm.
Within the medial femoral triangle there is a further lymph node that measures 62 x 19 x 23 mm. This node does maintain an ovoid configuration and fatty hilum whereas the other described nodes do not.

Conclusion
Left inguinal and left iliac fossa enlarged and pathologically appearing lymph nodes. Lymphoma could have this appearance and FNA is recommended.

Results discussed with Dr Hearnden at the time of reporting.

Thank you for referring Jessica Jenkins.

Dr Tanya Wood

Click here to view all images in InteleConnect (2019E0023501-US)

Jenkins , Jessica Mary
2 Cycas Street ARANA HILLS 4054
Phone: 0404678736

Birthdate:	27/07/1981	**Sex:**	F	**Medicare Number:**	42878776161
Your Reference:	DR=5077117X	**Lab Reference:**	2019RH0010029		
Laboratory:	QSCAN Radiology				
Addressee:	Dr. ROSS BOURNE	**Referred by:**	Dr. ROSS BOURNE		
Name of test:	Ultrasound Guided FNA, Pathology Results - US				
Requested	29/11/2019	**Collected:**	29/11/2019	**Reported:**	03/12/2019 17:45:00

Qscan RADIOLOGY CLINICS

Ultrasound Guided FNA, Pathology Results - US

Patient:	JENKINS, JESSICA	**Date of Birth:**	1981-07-27	**Sex:**	F
Address:		**Medicare Number:**		**Phone:**	CP 0404678736
Sender:	Carey, Brian	**Addressee:**	BOURNE, Dr Ross	**Referred by:**	Dr Ross Bourne
Lab Reference:	2019RH0010029				
Requested:		**Collected:**	29/11/2019 9:26:00 AM	**Reported:**	3/12/2019 5:45:00 PM

ULTRASOUND GUIDED FNA, PATHOLOGY RESULTS - US

History
Left inguinal lymphadenopathy for FNA.

Findings
Informed consent. Aseptic technique. Under ultrasound guidance and following local anaesthesia, a morphologically abnormal left inguinal lymph node was sampled with 3 passes of a 25-gauge needle. Adequate material confirmed by the Cytologist. No immediate complication.

Thank you for referring Jessica Jenkins.

Dr Brian Carey

Click here to view all images in InteleConnect (2019RH0010029-US)

Jenkins , Jessica Mary
2 Cycas Street ARANA HILLS 4054
Phone: 0404678736

Birthdate:	27/07/1981	**Sex:**	F	**Medicare Number:**	42878776161
Your Reference:	DR=5077117X	**Lab Reference:**	2019RH0010246		
Laboratory:	QSCAN Radiology				
Addressee:	Dr. ROSS BOURNE	**Referred by:**	Dr. ROSS BOURNE		
Name of test:	Ultrasound Core Biopsy of Mass, Pathology Results - US				
Requested	05/12/2019	**Collected:**	05/12/2019	**Reported:**	10/12/2019 11:39:00

Ultrasound Core Biopsy of Mass, Pathology Results

Patient:	JENKINS, JESSICA	**Date of Birth:**	1981-07-27	**Sex:**	F
Address:		**Medicare Number:**		**Phone:**	CP 0404678736
Sender:	OSMAN, Dr Aziz	**Addressee:**	BOURNE, Dr Ross	**Referred by:**	Dr Ross Bourne
Lab Reference:	2019RH0010246				
Requested:		**Collected:**	5/12/2019 9:47:00 AM	**Reported:**	10/12/2019 11:39:00 AM

ULTRASOUND CORE BIOPSY LEFT INGUINAL LYMPH NODES

History
Enlarged left inguinal lymph nodes. FNA suggest B-cell proliferative disorder. Haematology request core biopsy.

Findings
Consent obtained. Aseptic technique utilised. Xylocaine local anaesthetic to skin and soft tissues. Under ultrasound guidance, for a 18-gauge core biopsies were performed within the left superficial inguinal lymph node. 2 cores were sent in Formalyn and to cause in normal saline. The procedure was well tolerated. There were no immediate complications. The samples were sent to QML pathology for histology and flow cytometry.

Conclusion
Ultrasound guided left inguinal lymph node core biopsy performed uneventfully.

Thank you for referring Jessica Jenkins.

Dr Aziz Osman

Click here to view all images in InteleConnect (2019RH0010246-US)

JENKINS, JESSICA MARY
2 CYCAS ST, ARANA HILLS. 4054
Phone: 04 23448807
Birthdate: 27/07/1981 **Sex:** F **Medicare Number:** 42878776161
Your Reference: **Lab Reference:** 19-97144484-CMM-0
Laboratory: QML Pathology
Addressee: DR ROSS BOURNE **Referred by:** DR AZIZ OSMAN
Copy to:
CANCER REGISTRY QUEENSLAND
DR JASON P BUTLER
DR ROSS BOURNE

Name of Test: MASTER LYMPHOMA/LEUKAEMIA
Requested: 05/12/2019 **Collected:** 05/12/2019 **Reported:** 07/12/2019 17:34

CELL SURFACE MARKER ANALYSIS
Specimen Submitted : Left Inguinal Lymph Node
Population Reported: Comprehensive Lymphoid Phenotype Reported.

T CELL LINEAGE		B CELL LINEAGE		SPECIALTY MARKERS	
CD 7	58 %	CD19	22 %	CD25	13 %
CD 2	54 %	CD10	<1 %	CD11c	4 %
CD 5	77 %	CD20	32 %	CD103	11 %
CD 3	66 %	SmIg	22 %	CD43	31 %
CD 4	51 %	kappa	18 %	CD123	1 %
CD 8	13 %	lambda	4 %		
CD56	2 %	FMC 7	2 %		
		CD23	9 %		
		CD79b	7 %		
		CD200	31 %		

Comment:
Number of cells available for analysis:
- Adequate.
Proportion of lymphoid cells:
- 80 %.
Viability:
- Poor.
Results to be treated with reserve.

The majority of the lymphoid cells are T cells.
A monoclonal B cell population expressing kappa light chain on the surface membrane is present.
The B-cell phenotype is:
CD19+, CD20++, FMC7 weak, CD38+, CD79b weak.
CD43 is equivocal. CD5 and CD10 appear negative.
Some B-cells appear larger than background T-cells.

CONCLUSION:
B-cell Lymphoproliferative Disorder (Unclassified).

Correlate with histology.

Dr E. Simleit [Haematologist]

C13732; AT18156

//CD4

Tests Completed:LEUKAEMIA MARKER STUDIES
Tests Pending :

JENKINS, JESSICA MARY
2 CYCAS ST, ARANA HILLS. 4054
Phone: 04 23448807
Birthdate: 27/07/1981 **Sex:** F **Medicare Number:** 42878776161
Your Reference: **Lab Reference:** 19-97144484-PWH-0
Laboratory: QML Pathology
Addressee: DR ROSS BOURNE **Referred by:** DR AZIZ OSMAN
Copy to:
CANCER REGISTRY QUEENSLAND
DR JASON P BUTLER
DR ROSS BOURNE

Name of Test: PWL HISTOPATHOLOGY
Requested: 05/12/2019 **Collected:** 05/12/2019 **Reported:** 09/12/2019 16:18

HISTOPATHOLOGY REPORT
ACCESSION No. BR19-073082

MACROSCOPIC EXAMINATION
Left groin lymph node: Specimen received in formalin and consists of multiple fragments of core tissue ranging in length from 2-9 mm and all measure 1 mm in diameter. All tissue submitted, 1A.

MICROSCOPIC EXAMINATION
Left groin lymph node: The core biopsy shows a large cell lymphomatous infiltrate with many cells showing suggestion of monocytoid-like appearance with voluminous clear cytoplasm.

Immunohistochemistry: CD20 +; CD3 numerous admixed T-lymphocytes with similar staining seen with CD 5 and CD 43; CD21 remnants of distorted FDC meshwork; Cyclin D1 negative; Ki-67 75%; CD79a similar staining pattern to CD20; Bcl-2 +; BCL-6 +; CD 10 negative; Kappa and Lambda show apparent Kappa light chain restriction.

Flow cytometry: Refer full report; B-cell lymphoproliferative disorder unclassified.

DIAGNOSIS: LEFT GROIN LYMPH NODE: CONSISTENT WITH DIFFUSE LARGE B-CELL LYMPHOMA. REFER COMMENT.

COMMENT: Excisional nodal biopsy to exclude a background lower grade lymphoma (in particular marginal zone) and allow confirmation of diagnosis is indicated.

Thank you for referring to QML Pathology.
Reported by: Dr. Debra Norris
Validated by: Dr. Debra Norris; 09/12/2019
Reported at Murarrie, QLD.

Tests Completed:LEUKAEMIA MARKER STUDIES
Tests Pending :

JENKINS, JESSICA MARY
2 CYCAS ST, ARANA HILLS. 4054
Phone: 04 23448807
Birthdate: 27/07/1981 **Sex:** F **Medicare Number:** 42878776161
Your Reference: **Lab Reference:** 19-97144484-PWH-0
Laboratory: QML Pathology
Addressee: DR ROSS BOURNE **Referred by:** DR AZIZ OSMAN
Copy to:
CANCER REGISTRY QUEENSLAND
DR JASON P BUTLER
DR ROSS BOURNE

Name of Test: PWL HISTOPATHOLOGY
Requested: 05/12/2019 **Collected:** 05/12/2019 **Reported:** 10/12/2019 16:31

SUPPLEMENTARY REPORT - 10/12/2019 03:55PM
HISTOPATHOLOGY REPORT
ACCESSION No. BR19-073082

MACROSCOPIC EXAMINATION
Left groin lymph node: Specimen received in formalin and consists of multiple fragments of core tissue ranging in length from 2-9 mm and all measure 1 mm in diameter. All tissue submitted, 1A.

MICROSCOPIC EXAMINATION
Left groin lymph node: The core biopsy shows a large cell lymphomatous infiltrate with many cells showing suggestion of monocytoid-like appearance with voluminous clear cytoplasm.

Immunohistochemistry: CD20 +; CD3 numerous admixed T-lymphocytes with similar staining seen with CD 5 and CD 43; CD21 remnants of distorted FDC meshwork; Cyclin D1 negative; Ki-67 75%; CD79a similar staining pattern to CD20; Bcl-2 +; BCL-6 +; CD 10 negative; Kappa and Lambda show apparent Kappa light chain restriction.

Flow cytometry: Refer full report; B-cell lymphoproliferative disorder unclassified.

DIAGNOSIS: LEFT GROIN LYMPH NODE: CONSISTENT WITH DIFFUSE LARGE B-CELL LYMPHOMA. REFER COMMENT.

COMMENT: Excisional nodal biopsy to exclude a background lower grade lymphoma (in particular marginal zone) and allow confirmation of diagnosis is indicated.

Thank you for referring to QML Pathology.
Reported by: Dr. Debra Norris
Validated by: Dr. Debra Norris; 09/12/2019
Reported at Murarrie, QLD.

SUPPLEMENTARY REPORT
Left groin lymph node: MUM1 + (greater than 30%).

COMMENT: As such, this DLBCL, is of non-GCB subtype (CD10 -, BCL6 +, MUM1 +).
I would still advocate excisional nodal biopsy as previously indicated.

Supplementary report by: Dr. Debra Norris
Validated by: Dr. Debra Norris; 10/12/2019
Reported at Murarrie, QLD.

Tests Completed:LEUKAEMIA MARKER STUDIES
Tests Pending :

TREATING SPECIALIST'S STATEMENT
INITIAL CLAIM FORM
TRAUMA

Issued 1 March 2019

We value your feedback as the treating specialist and we seek your independence in completing this form.

We understand this form may take some time initially but in the long term will reduce the amount of queries to yourself and your patient. This will allow for a speedier assessment and greater understanding of the claim.

Please note if there is a charge for completion of this form, it is the responsibility of your patient.

If you have any queries do not hesitate to contact us on 1800 024 812.

This form is to be completed by your treating specialist Please use block letters

1. Insured's name JESSICA JENKINS
   Date of birth 27/07/81
2. Are you the Insured's usual treating specialist? ..... Yes ☑ No ☐
3. a. Please provide the name of the referring doctor and the date of referral
   DR ROSS BOURNE, ARANA HILLS 02/12/19
   b. Please state your specialty
   CLINICAL HAEMATOLOGIST
4. Date the Insured was **first ever** seen by you 06/12/19
5. Date the Insured was **first seen for the current condition** 06/12/19
6. When did symptoms first appear? OCT/19
7. Please advise of the symptoms that led to the detection of the Insured's condition and how long these symptoms were present:
   a. Description of symptoms that led to detection
   LUMP (R) INGUINAL REGION
   ANOREXIA
   NON-ORGANISM SWEATS
   b. Length of time symptoms present
   ~3/52 PRIOR TO PRESENTATION TO GP
8. Exact nature and description of current symptoms
   FATIGUE
   URINARY } SEE TO CHEMOTHERAPY
   CONSTIPATION
   NAUSEA

9. a. What is your current diagnosis for the insured?

DIFFUSE LARGE B-CELL LYMPHOMA
STAGE III
IPI 2/5.

b. Date of diagnosis ..... / /

10. Please provide details of tests, surgical procedures, scans that have been performed which have assisted in forming your diagnosis. Please also provide dates and results.

Important: please attach copies of all investigations/results.

Details of tests/scans/procedures	Date of result	Results/findings
CT PET	10/12/19	STAGE III D
ECHOCARDIOGRAM	18/12/19	(N)
	/ /	
	/ /	
	/ /	

11. Please advise at what stage/level the insured's condition is presently at:

STAGE III

12. Has the insured ever had the same or similar condition? ..... Yes ☐ No ☒

If 'yes', please provide the date and details. ..... / /

13. Are any other sicknesses present that affect the current condition? ..... Yes ☐ No ☒

If 'yes', please describe.

14. What treatment/surgery has been undertaken to date and please advise of the effectiveness of treatment?

R-CHOP — 1ST OF 6 CYCLES COMPLETED

If available please provide a copy of the operation report.

15. Is there any further treatment planned?.....Yes ☐ No ☐

If 'yes', please details.

Ongoing Recall As Above

16. Please comment on the Insured's current status.

Stable, Awaiting for Side-Effect from Rx

17. Please advise if there is a history of contributing factors leading to the connection or causation of the Insured's condition (e.g. health or lifestyle factors).

Nil

18. Is there a family history with regard to this condition?.....Yes ☐ No ☒

If 'yes', please details.

Family member (Relationship to insured)	Condition/sickness	Age at onset (Approx)	Age at Death (If applicable)

19. Has the Insured been referred to any other doctors or specialists? If so, please provide details in the table below.

Name of doctor/specialist	Specialty	Date referred/ Date of consults	Address and phone number
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	
		/ /	

20. Any additional comments that may assist us in assessing this claim.

Please complete the declaration overleaf.

Additional information

Please provide your details below and we thank you for completing this form.

I hereby declare that the above statements are true and correct.

Signed X

Date 08 / 04 / 2020

Name JASON BOTHA

Qualifications MBBS MMEDSCI RANZCP FRCPA

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BUTTERFIELD ST HERSTON

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