Attending Physician Statement

(Hospitalisation/ Accident/ Total & Permanent Disability Claim)

Important Notes

1. This form is to be completed by the life insured's (Patient's) doctor.
2. To enable us to process the claim promptly, please ensure that the form is fully completed. If any of the questions is not applicable, please state "NA".
3. We reserve our rights to request for additional information or documents, if needed.
4. If you have any questions while completing this form, please contact our Customer Care Centre at +65 6880 4888.
5. **For Critical Illness Claim, please DO NOT use this attending physician statement form but to use the Attending Physician Statement for the type of Critical Illness that you are claiming for**

1. Patient's Information

Full name of Patient (Life Assured)	NRIC No./ Passport No. (for foreigners only)

2. Current Medical Condition

(i) Details of Consultation

Date of Consultation	Symptoms Presented	Duration of Symptom	Diagnosis	Date of First Diagnosis	Medical Treatment Provided

(ii) Did you inform the Patient of the diagnosis?

☐ Yes ☐ No

If "No", please state the reason

(iii) Was Patient hospitalised or undergone any surgery?

☐Yes ☐ No

If "Yes", please provide details

Name of Hospital	Period of Hospitalisation/ Surgery		Diagnosis	Nature of Surgery (if any)
	From	To		

(iv) If more than 1 surgical procedures were performed during the same surgery, were they performed through the same or different incision?

(v) Did the Patient consult any doctor before consulting you?

☐ Yes ☐ No

If "Yes", please provide details

Name of doctor	Hospital/ Clinic	Date of Consultation	Diagnosis

(vi) Is the Patient's condition caused by an accident?

☐ Yes ☐ No

If "Yes", please provide details

Date of Accident	Cause of Accident	Extent of Bodily Injury	Bodily Injury Consistent with Accident?
			☐Yes ☐No

(vii) Was the Patient given medical leave?

If "Yes", please state the periods of medical leave

_____

(viii) In your opinion, how long is the medical condition or disability expected to last as a result of this accident?

_____

_____

(ix) Are there any other medical conditions which Patient has which will or likely to prolong the recovery period?

_____

_____

(x) Was the Patient under the influence of alcohol/ drugs at the time of accident?

☐ Yes ☐ No

If "Yes", please state the blood alcohol content/ drug type of quantity consumed

_____

(xi) Is the Patient's medical condition or surgery performed related or due to (Please circle the Medical Condition and tick against "Yes" or "No") :

a) pregnancy, infertility, sub-fertility, childbirth, birth control, sterilisation, miscarriage or abortion? ☐Yes ☐No

b) birth defects, congenital sickness or abnormalities? ☐Yes ☐No

c) sexually transmitted disease, AIDS or HIV related illness? ☐Yes ☐No

d) self-inflicted injury? ☐Yes ☐No

e) depression, mental or nervous disorder? ☐Yes ☐No

f) alcoholism or drug abuse or any injury or illness suffered after taking intoxicating liquors or drugs? ☐Yes ☐No

g) cosmetic reasons or elective surgery? ☐Yes ☐No

h) obesity, weight reduction or weight improvement? ☐Yes ☐No

i) dental care or treatment? ☐Yes ☐No

3. Medical History

(i) Does Patient have any other medical condition?

☐ Yes ☐ No

If "Yes", please provide details

Medical Condition	Date Medical Condition was Diagnosed	Type of Medical Treatment	Name & Address of Doctor

4. Total & Permanent Disability (TPD) (applicable only for Patient who is TPD)

(i) Patient's occupation before disability _____

(ii) Patient's current occupation (if any) _____

(iii) Please describe fully the nature and severity of the Patient's disabilities

_____

_____

(iv) Is the Patient in constant need of care and attention?

☐ Yes ☐ No

If "Yes", since when?_____

(v) Is the Patient confined to his/her home under medical supervision or in a hospital or similar institution?

☐ Yes ☐ No

If "Yes", since when?_____

(vi) If "Yes" to Question (iv) & (v) above, is the disability continuous, expected to be permanent, and has lasted for at least 6 months?

☐ Yes ☐ No

(vii) Did the Patient's disability result in the complete and continuous inability of Patient to engage in any business, occupation, work or profession of any kind for profit, compensation, wages or remuneration?

☐ Yes ☐ No

If "Yes", when did such disability commence?_____

(viii) Is the Patient terminally ill?

☐ Yes ☐ No

(ix) Is the Patient mentally incapacitated?

☐ Yes ☐ No

If "Yes", is the Patient mentally capable of receiving or handling his/ her own financial matters eg. money?

☐ Yes ☐ No

(x) Is the Patient totally and permanently unable to perform 3 of the 6 Activities of Daily Living "ADLs" even with the aid of special equipment, and always require physical assistance of another person throughout the physical activity for a continuous period of at least 6 months?

☐ Yes ☐ No

If "Yes", when did such disability commence? _____

Please tick ☑ against the ADLs that Patient is unable to perform:-

a) Transferring	☐Yes	☐No
b) Mobility	☐Yes	☐No
c) Toileting	☐Yes	☐No
d) Washing	☐Yes	☐No
e) Feeding	☐Yes	☐No

_____ _____

Date Signature & Official Stamp of Doctor