CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Loss Of Independent Existence (Early Stage / Intermediate Stage / Critical Stage)

(To be completed by the Life Assured's attending medical specialist)

Important Notes:

(1) To enable us to proceed with the claim, it is mandatory to enclose all relevant clinical, radiological, histological, operation and laboratory report by attaching them to this page.
- (a) Copies of all reports of laboratory tests invesigated for disease
- (b) Copies of X-ray investigating for loss of fingers due to accident (if available)
- (c) Referral letter (if any)

(2) Please circle the questions below where appropriate.

Section 1 : Details of Policyholder / Life Assured

Full Name: _____

NRIC / Passport No.: | | | | | | | | | | | | |

Section 2 : Details of disease

(1) Date when patient first consulted you for the condition? DD / MM / YY

(2) When was the last consultation? DD / MM / YY

(3) Please state symptoms presented and symptom date first appeared.

Complained of symptoms	Duration of symptoms	Symptom date (DD/MM/YY)

(4) Please provide the exact diagnosis. _____

(5) Date of diagnosis. DD / MM / YY

(6) Date when patient / patient's next of kin was first informed of the diagnosis. DD / MM / YY

(7) Were you the doctor who first diagnosed the patient with this condition? Yes / No

(8) If you are not the first doctor who diagnosed the patient with this condition, please provide:
- (a) Name and address of the doctor who first made the diagnosis or had treated the condition.

- (b) Please provide the name and address of referral doctor.

Signature of the Medical Specialist _____ Date _____

(9) Please elaborate the underlying cause of patient's condition.

(10) Was the patient's condition a result of an accident? Yes / No

If Yes, please provide following information in details.

(a) Please provide the date of accident. DD / MM / YY

(b) Please describe where and how did the accident happened.

(c) Had the patient suffered from total and irreversible physical loss of all fingers including thumb at the metacarpophalangeal joints of the same hand? Yes / No

(d) Please describe the extent and severity of the bodily injuries/ disability sustained.

(e) Was the accident due to a self-inflicted injury? Yes / No

(11) Please state date of last assessment in relation to patient's ability to perform activities of daily living. DD / MM / YY

(12) Based on the last date of assessment, please state your assessment if the patient is able to perform (whether aided* or unaided) the following Activities of Daily Living?

**Aided shall mean with the aid of the special equipment, device and/or apparatus and not pertaining to human aid.*

Activitiy	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From	To
Washing: Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	Yes	No		
Dressing: Ability to put on, take off, secure and unfasten all garments and,as appropriate, any braces artificial limbs or other surgical appliances.	Yes	No		
Transferring: Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		
Mobility: Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting: Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	Yes	No		
Feeding: Ability to feed oneself once food has been prepared and made available.	Yes	No		

Signature of the Medical Specialist

Date

(13) Please describe the prognosis of the patient's condition.

(a) If patient's condition is likely to improve, please state the extend of improvement expected and estimated date of recovery.

(b) If patient's condition is likely to deteriorate or remain static, please elaborate with reasons how you arrive at this opinion.

(14) Please circle your reply to the Questions below, if patient's condition or surgery performed in any way related to:

(a) AIDS, AIDS-related complex or infection by HIV?	Yes	No
(b) Drug abuse or use of drug not prescribed by registered medical practitioner?	Yes	No
(c) Alcohol abuse or misuse?	Yes	No
(d) Congenital anomaly or defect?	Yes	No
(e) Non-organic diseases such as neurosis and psychiatric illnesses?	Yes	No

(15) If Yes to any Question 14 (a) to (d), please provide following details and a copy of investigation test result.

Exact diagnosis	Diagnosis date (DD/MM/YY)	Name and address of treating doctor

(16) Please describe the Life Assured's mental and cognitive abilities.

(17) In accordance to Singapore's Mental Capacity Act (Cap 177A), is patient mentally incapacitated? Yes No

(18) Does the Life Assured have or ever had any other medical conditions?

If Yes, please advise further details.

Medical condition	Diagnosis date (DD/MM/YY)	Name and address of treating doctor

(19) Does the Life Assured have any family history? Yes No

If Yes, please provide details including relationship to the Life Assured, nature of condition and age of onset.

Age of onset	Relationship to Life Assured	Nature of Condition

(20) Was the Life Assured ever suffered from similar condition or any other Major Illnesses previously? Yes No

If Yes, please further elaborate in details.

Medical condition	Diagnosis date (DD/MM/YY)	Name and address of treating doctor

Signature of the Medical Specialist

Date

(21) Please provide any other information which maybe of assistance to us in assessing this claim.

Section 3 : To be completed by Medical Specialist

Signature and Official Stamp

Name: _____

Address: _____

_____

_____

Date: ☐☐ / ☐☐ / ☐☐☐☐
DD / MM / YY