

**LIVING ASSURANCE CLAIM
DOCTOR'S STATEMENT**

**DOCTOR'S STATEMENT FOR:
SEVERE RHEUMATOID ARTHRITIS**

* Please delete where appropriate

For Official Use

G E L S -

Name of Life Assured:

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

1. (a) Are you the Life Assured's usual medical doctor? YES / NO*

(b) If "YES", since what date?

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

(c) Over what period do your records extend? From

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

to

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

(d) If you are not the Life Assured's usual medical doctor, please provide the name, address and qualification of the Life Assured's usual medical doctor.

2. (a) Date when Life Assured consulted you for this illness:

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

(b) Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (D/M/Y)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

What is the source of this information?

Patient / Referring Doctor / Others*

If "Others", please specify:

(c) Diagnosis:

Date

Signature of Doctor



3. (a) Please provide the full and exact details of the diagnosis.

(b) Date when illness was FIRST diagnosed:

Day	Month	Year

(c) Diagnosis was first made by (name of doctor):

(d) Date when the Life Assured first became aware of the condition:

Day	Month	Year

4. Is there widespread joint destruction?

5. What clinical deformity is seen at these joint areas?

(a) Hands

(b) Wrists

(c) Elbows

(d) Knees

(e) Hips

(f) Ankle

(g) Cervical Spine

(h) Metatarsophalangeal joints in the feet

Date

Signature of Doctor

6. Please comment if the diagnosis is supported by the following:
- (a) Morning stiffness _____
- _____
- (b) Symmetric arthritis _____
- _____
- (c) Presence of rheumatoid nodules _____
- _____
- (d) Elevated titres of rheumatoid factors _____
(Please enclose test results)
- _____
- (e) Radiographic evidence of severe involvement _____
(please enclose test results)
- _____

7. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory / investigation results.

8. Has the Life Assured previously suffered from the condition specified above or any related illness? YES / NO*
If "YES", please give details including dates of consultations and the resulting diagnosis.

9. Did the Life Assured consult other doctors for this illness or its symptoms BEFORE he / she consulted you? YES / NO*
If "YES", please give name(s) and address(es) of the doctor(s) whom he / she consulted.

Name of Doctor	Name of Clinic / Hospital and Address

Date

Signature of Doctor

10. Please provide dates and results of all HIV and antibody tests done. Please also attach copies of all relevant laboratory reports.

11. Does the Life Assured have any personal history of any other major medical or psychiatric condition? YES / NO*
If "YES", please give details including nature of condition, date of onset, treatment received and current status of the condition.

12. Does the Life Assured have any family history of any major medical condition? YES / NO*
If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

13. Please provide any other information which may be of assistance to us in assessing this claim.

Date

Signature & Official Stamp of Doctor