

**JUNIOR LIVING ASSURANCE / MAXCARE JUNIOR CLAIM
DOCTOR'S STATEMENT**

**DOCTOR'S STATEMENT FOR:
SEVERE EPILEPSY**

* Please delete where appropriate

For Official Use

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| G | E | L | S | - | | | | | | | | | | | | | | | |
| O | A | C | 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 |
|-----|-------|------|
| | | |

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

| Day | Month | Year |
|-----|-------|------|
| | | |

 to

| Day | Month | Year |
|-----|-------|------|
| | | |

(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 |
|-----|-------|------|
| | | |

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

| Symptoms Presented at First Consultation | Date Symptoms First Started (D/M/Y) |
|--|-------------------------------------|
| | |
| | |
| | |

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 |
|-----|-------|------|
| | | |

(e) Date when the Life Assured's PARENT first became aware of the condition:

| Day | Month | Year |
|-----|-------|------|
| | | |

4. Has Life Assured experience recurrent unprovoked tonic-clonic or grand mal seizures due to a disorder of the brain? YES / NO*

If "YES", please provide the date.

| Day | Month | Year |
|-----|-------|------|
| | | |

5. Has Life Assured undergone neuro surgery for treatment of epileptic seizures? YES / NO*

If "YES", please provide the date.

| Day | Month | Year |
|-----|-------|------|
| | | |

6. Is the epilepsy due to febrile seizures alone? YES / NO*

7. Is the epilepsy due to absence (petit mal) seizures alone? YES / NO*

8. Is the Life Assured taking prescribed anti-epilepsy (anti-convulsant) medication? YES / NO*

If "YES", please state the period the Life Assured has been taking prescribed anti-epilepsy (anti-convulsant) medication.

From

| Day | Month | Year |
|-----|-------|------|
| | | |

 to

| Day | Month | Year |
|-----|-------|------|
| | | |

9. Please provide details of all investigations performed including electroencephalography (EEG), Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) and treatment prescribed. Please attach a copy of the laboratory/investigation results.

Date

Signature of Doctor

10. 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.

11. 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 |
|----------------|---------------------------------------|
| | |
| | |
| | |

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

13. 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.

14. 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.

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

Date

Signature and Official Stamp of Doctor