

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

**DOCTOR'S STATEMENT FOR:
GLOMERULONEPHRITIS WITH NEPHROTIC SYNDROME**

* 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. Please comment whether the Life Assured has nephrotic syndrome.

5. (a) Please describe any treatment prescribed to the Life Assured.

(b) Period of this treatment: From

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

 to

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

(c) Has the Life Assured been following this course of treatment or is he/she non-compliant?

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

7. 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.

Date

Signature of Doctor

8. 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 |
|----------------|---------------------------------------|
| | |
| | |
| | |

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

10. 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.

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

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

Date

Signature & Official Stamp of Doctor