GOLDEN PROTECTOR CLAIM DOCTOR'S STATEMENT



* Please	delete where appropriate For Official Use							
Name o	f Life Assured:							
NRIC/ F	Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F							
1. Da	te of Accident:							
Da	te of first consultation for the current condition: Day Month Year Date(s) of subsequent consultation(s):							
lf t	ne Life Assured had consulted another doctor BEFORE consulting you, please give name and address of that doctor.							
_								
2. (a)	Detailed description of the injuries:							
()								
(b)	Please state the diagnosis.							
(c)	Detailed description of the accident:							
(d)	Were the injuries caused solely by the accident described above? YES / NO*							
(e)	(i) Were there any underlying illnesses/ conditions that attributed to the accident? YES / NO*							
(-)	If "YES", please provide full details of condition (including the type of condition, the date of onset, the extent of physical/ mental infirmity) and describe how it attributed to the accident.							
	(ii) What was the proximate cause of the injuries/ disabilities?							
(f)	Was the Life Assured under the influence of alcohol/ drugs at the time of the accident? YES / NO*							
	If "YES", please state blood alcohol content/ drug type and quality consumed:							
	Date Signature of Doctor							



(g)	Did the injuries result from a self-inflicted act? If "YES", please give full description.	YES / NO ²	
3. WI	hat is the Life Assured's occupation and nature of work?		
4. If L	Life Assured had been hospitalised or had undergone surgery, please state:		
(i)	Date admitted: Day Month Year (ii) Day	te discharged:	Day Month Year
(iii)	Name of Hospital:		
(iv) Nature of Surgical Procedure		
	Day Month Year		
(v)			
(vi) Is further surgery likely to be required? Day Month Year		YES / NC
	If "YES", please specify tentative date of surgery:		
5. Die	d the Life Assured suffer any fractures, dislocations or burns?		YES / NO
If "	YES", please tick where applicable.		
(i)	Fractures of hip or pelvis (excluding thigh or coccyx)		
	☐ Multiple fractures, at least one compound and at least one complete	☐ All oth	ner compound fractures
	☐ Mulitple fractures, at least one complete	Others	s fractures
(ii)	Fractures of thigh or heel		
	☐ Multiple fractures, at least one compound and at least one complete	☐ All oth	er compound fractures
	☐ Multiple fractures, at least one complete	☐ Other	fractures
(iii)	Fractures of lower leg, skull, claride, ankle, elbows, upper or lower arm (including w fractures)	rists but exclud	ling collen-type
	☐ Multiple fractures, at least one compound and at least one complete	☐ All oth	er compound fractures
	☐ Depressed fracture of the skull needing surgical intervention	☐ Other	fractures
	☐ Multiple fractures, at least one complete		
	Date		Signature of Doctor

(iv)	Fra	Fractures of collen-type fracture of the lower arm				
		Compound fracture		Other fractures		
(v)	Fractures of shoulder blade, knee cap, sternum, hand (excluding fingers and wrists), foot (excluding toes or heel)					
		All compound fractures		Other fractures		
(vi)	i) Fractures of spinal column (vertebrae but excluding coccyx)					
		All compressions fractures		All spinous, transvere process of pedicle fractures		
		Fracture leading to permanent neurological damage		Other vertebrae fractures		
(vii)	Fra	ctures of lower jaw				
		Multiple fractures, at least one compound and at least one complete		All other compound fractures		
		Multiple fractures, at least one complete		Other fractures		
(viii)	Fra	ctures of rib or ribs, cheek bone, coccyx, upper jaw, nose, toe or toes	, fing	ger or fingers		
		Multiple fractures, at least one compound and at least one complete		All other compound fractures		
		Multiple fractures, at least one complete		O ther fractures		
(ix)	Bur	ns: 2nd or 3rd degree burns on				
		at least 27% of body surface		at least 18% of body surface		
		at least 9% of body surface		at least 4.5% of body surface		
(x)	Dis	locations requiring surgery under anaesthesia				
		Spine or back, diagnosed by X-ray (excluding slipped disc)		Hip		
		Knee		Wrist or elbow		
		Ankle, shoulder blade or collarbone		Fingers, toes or jaw		
	☐ Internal injuries resulting in open abdominal or thoracic surgery (excluding hernia)					
		Date		Signature of Doctor		

ACTIVITIES OF DAILY LIVING ("ADL") FUNCTION (a) Please tick as applicable in relation to the Life Assured's ADL ability. Notes: "NO assistance" means the Life Assured requires no assistance to perform the ADL. "SOME assistance" means the Life Assured requires some assistance of another person up to 74% of the time to perform the ADL. "SUBSTANTIAL assistance" means the Life Assured requires another person at least 75% of the time to perform the ADL. "FULL assistance" means the Life Assured is not able to perform the ADL even with the aid of the special equipment, and always requiring the physical help of another person throughout the entire ADL. Washing (ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.) ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary). (ii) Dressing (ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.) ☐ SUBSTANTIAL assistance ■ NO assistance SOME assistance ☐ FULL assistance Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary). (iii) Toileting (ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate.) ☐ SOME assistance ☐ NO assistance ☐ FULL assistance ☐ SUBSTANTIAL assistance Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary). (iv) Mobility (ability to move indoors from room to room on level surfaces.) ☐ SUBSTANTIAL assistance NO assistance ☐ SOME assistance FULL assistance Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary). Date Signature of Doctor

((v)	Transferring (ability to move from a bed to an upright chair or wheelchair and vice versa.)							
		☐ NO assistance	SOME assistance	SUBSTANTIAL assistance	FULL assistance				
		Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).							
	(iv)	Feeding (ability to feed oneself food after it has been prepared and made available.)							
		\square NO assistance	☐ SOME assistance	☐ SUBSTANTIAL assistance	☐ FULL assistance				
		Comment (if assistan	nce is required, please inclu	de date (dd/mm/yy) when such assis	stance became necessa	ry).			
7.	(a)	Was the Life Assured suffering from any illness/ infirmity which was likely to protract the period of disability? YES / NO* If "YES", please give details: Day Month Year							
		(i) Date of first diag							
		(iii) Name and addr	ess of doctor who made dia	ignosis:					
		(iv) How it protracts	the period of disability:						
	(b)	What would be the u	sual recovery time of the inj	uries if the Life Assured did not have	the illness/ infirmity?				
8. Has the Life Assured been admitted to any hospital before, either for the same or different cause? YES / NO* If "YES", please state.									
		Period(s) of Hospitalisation	Diagnosis	Hospital	Nam Attending	e(s) of g Doctor(s)			
). I	Please provide us with any other additional information that will enable the Company to assess this claim.								
-	Date Signature & Official Stamp of Docto					Stamp of Doctor			