

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

**DOCTOR'S STATEMENT FOR:
ENCEPHALITIS**

* Please delete where appropriate

For Official Use

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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. (a) Describe the initial episode:

(i) Nature of episode: _____

(ii) Date:

Day	Month	Year

(iii) Duration of acute symptoms: _____

(iv) Is the Life Assured able to return to normal duties? YES / NO*

If "YES", please state when:

Day	Month	Year

If "NO", please state the Life Assured's latest physical and mental limitations (with date of latest assessment).

Date	Neurological Limits

(b) Was there any neurological deficit 6 weeks after the date of diagnosis of Life Assured's encephalitis? YES / NO*
If "YES", please describe the neurological deficit.

(c) Is this neurological damage likely to be permanent? YES / NO*
If "NO", please provide details.

Date

Signature of Doctor

(d) Has there been severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum)?
YES / NO*

If "YES", please state which of the above: _____

(e) Is the severe inflammation of brain substance caused by viral infection? YES / NO*

If "YES", please provide details.

(f) Please provide names and addresses of any hospital or clinic to which the Life Assured was referred, together with the names of the consultants attended.

5. Was the encephalitis caused by HIV infection? YES / NO*

If "YES", please provide date and results of all HIV and antibody tests done. Please also attach copies of all relevant laboratory reports.

6. Please provide details of all investigations performed and treatment prescribed. Please 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.

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

Date

Signature of Doctor

9. 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.

10. 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.

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

Date

Signature & Official Stamp of Doctor