Attending Physician Statement
(Hospitalisation/ Accident/ Total & Permanent Disability Claim)

Important Notes
1. This form is to be completed by the life insured's (Patient’s) doctor.
2. To enable us to process the claim promptly, please ensure that the form is fully completed. If any of the questions is not applicable, please state “NA”.
3. We reserve our rights to request for additional information or documents, if needed.
4. If you have any questions while completing this form, please contact our Customer Service Centre at 1-800-8804888.
5. For Critical Illness Claim, please DO NOT use this attending physician statement form but to use the Attending Physician Statement for the type of Critical Illness that you are claiming for.

1. Patient’s Information

Full name of Patient (Life Assured)  NRIC No./ Passport No. (for foreigners only)

2. Current Medical Condition

(i) Details of Consultation

<table>
<thead>
<tr>
<th>Date of Consultation</th>
<th>Symptoms Presented</th>
<th>Duration of Symptom</th>
<th>Diagnosis</th>
<th>Date of First Diagnosis</th>
<th>Medical Treatment Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(ii) Did you inform the Patient of the diagnosis?

☐ Yes  ☐ No

If “No”, please state the reason

(iii) Was Patient hospitalized or undergone any surgery?

☐ Yes  ☐ No

If “Yes”, please provide details

<table>
<thead>
<tr>
<th>Name of Hospital</th>
<th>Period of Hospitalisation/ Surgery</th>
<th>Diagnosis</th>
<th>Nature of Surgery (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From</td>
<td>To</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(iv) If more than 1 surgical procedures were performed during the same surgery, were they performed through the same or different incision?

(v) Did the Patient consult any doctor before consulting you?

☐ Yes  ☐ No

If “Yes”, please provide details

<table>
<thead>
<tr>
<th>Name of doctor</th>
<th>Hospital/ Clinic</th>
<th>Date of Consultation</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(vi) Is the Patient’s condition caused by an accident?

☐ Yes  ☐ No

If “Yes”, please provide details

<table>
<thead>
<tr>
<th>Date of Accident</th>
<th>Cause of Accident</th>
<th>Extent of Bodily Injury</th>
<th>Bodily Injury Consistent with Accident?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

(vii) Was the Patient given medical leave?

If “Yes”, please state the periods of medical leave

(viii) In your opinion, how long is the medical condition or disability expected to last as a result of this accident?

_____________________________________________________________________________________________________

(ix) Is there any other medical conditions which Patient has which will or likely to prolong the recovery period?

_____________________________________________________________________________________________________

(x) Was the Patient under the influence of alcohol/ drugs at the time of accident?

☐ Yes  ☐ No

If “Yes”, please state the blood alcohol content/ drug type of quantity consumed

(xi) Is the Patient’s medical condition or surgery performed related or due to (Please circle the Medical Condition and tick against “Yes” or “No”):

a) pregnancy, infertility, sub-fertility, childbirth, birth control, sterilization, miscarriage or abortion? ☐ Yes ☐ No

b) birth defects, congenital sickness or abnormalities? ☐ Yes ☐ No
c) sexually transmitted disease, AIDS or HIV related illness? ☐ Yes ☐ No
d) self-inflicted injury? ☐ Yes ☐ No
e) depression, mental or nervous disorder? ☐ Yes ☐ No
f) alcoholism or drug abuse or any injury or illness suffered after taking intoxicating liquors or drugs? ☐ Yes ☐ No
g) cosmetic reasons or elective surgery? ☐ Yes ☐ No
h) obesity, weight reduction or weight improvement? ☐ Yes ☐ No
i) dental care or treatment? ☐ Yes ☐ No
3. Medical History

(i) Does Patient have any other medical condition?

☐ Yes  ☐ No

If “Yes”, please provide details

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Date Medical Condition was Diagnosed</th>
<th>Type of Medical Treatment</th>
<th>Name &amp; Address of Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Total & Permanent Disability (TPD) (applicable only for Patient who is TPD)

(i) Patient’s occupation before disability _________________________________________________________________

(ii) Patient’s current occupation (if any) _________________________________________________________________

(iii) Please describe fully the nature and severity of the Patient’s disabilities

_________________________________________________________________________________________________

_________________________________________________________________________________________________

(iv) Is the Patient in constant need of care and attention?

☐ Yes  ☐ No

If “Yes”, since when?_______________________________________________________________________________

(v) Is the Patient confined to his/her home under medical supervision or in a hospital or similar institution?

☐ Yes  ☐ No

If “Yes”, since when?_______________________________________________________________________________

(vi) If “Yes” to Question (iv) & (v) above, is the disability continuous, expected to be permanent, and has lasted for at least 6 months?

☐ Yes  ☐ No

(vii) Did the Patient’s disability result in the complete and continuous inability of Patient to engage in any business, occupation, work or profession of any kind for profit, compensation, wages or remuneration?

☐ Yes  ☐ No

If “Yes”, when did such disability commence?___________________________________________________________
(viii) Is the Patient terminally ill?

☐ Yes  ☐ No

(ix) Is the Patient mentally incapacitated?

☐ Yes  ☐ No

If “Yes”, is the Patient mentally capable of receiving or handling his/her own financial matters eg. money?

☐ Yes  ☐ No

(x) Is the Patient totally and permanently unable to perform 3 of the 6 Activities of Daily Living “ADLs” even with the aid of special equipment, and always require physical assistance of another person throughout the physical activity for a continuous period of at least 6 months?

☐ Yes  ☐ No

If “Yes”, when did such disability commence? ________________________________

Please tick ☒ against the ADLs that Patient is unable to perform:-

a) Transferring  ☐Yes  ☐No

b) Mobility  ☐Yes  ☐No

c) Toileting  ☐Yes  ☐No

d) Washing  ☐Yes  ☐No

e) Feeding  ☐Yes  ☐No

________________________________________  ________________________________
Date  Signature & Official Stamp of Doctor