



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)
<input type="text"/>	<input type="text"/>

2. Current Medical Condition

(i) Details of Consultation

Date of Consultation	Symptoms Presented	Duration of Symptom	Diagnosis	Date of First Diagnosis	Medical Treatment Provided

(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

Name of Hospital	Period of Hospitalisation/ Surgery		Diagnosis	Nature of Surgery (if any)
	From	To		

(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

Name of doctor	Hospital/ Clinic	Date of Consultation	Diagnosis

(vi) Is the Patient's condition caused by an accident?

Yes No

If "Yes", please provide details

Date of Accident	Cause of Accident	Extent of Bodily Injury	Bodily Injury Consistent with Accident?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

(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

Medical Condition	Date Medical Condition was Diagnosed	Type of Medical Treatment	Name & Address of Doctor

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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Mobility | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Toileting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Washing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) Feeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Date

Signature & Official Stamp of Doctor