



**Living Benefit Claim - Doctor's Statement
Congenital Illnesses Benefit – Absence of Two Limbs**

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

A) Patient's Particulars									
Name of Patient	Gender								
NRIC / FIN / Passport / Birth Certificate No.	Date of Birth (ddmmyyyy) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
B) Patient's Medical Records									
1) Please indicate the period that is documented in the hospital/clinic's record:									
(i) Date of First consultation (ddmmyyyy):	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(ii) Date of Last consultation (ddmmyyyy):	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(iii) Number of consultations during the above period:									
(iv) Name of hospital/clinic and reasons for consultations (with dates):									
2) Are you the patient's usual medical doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", since when? (ddmmyyyy):	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
If "No", please provide name and address of the patient's regular doctor:									
3) Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please provide:									
(i) Date referred (ddmmyyyy):	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(ii) Reason for referral:									
(iii) Name and address of referring doctor:									
If "No", please indicate how the patient came to consult at your hospital/clinic? (e.g. A&E.)									
4) Have you referred the patient to any other doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No									
(i) Date referred (ddmmyyyy):	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(ii) Reason for referral:									
(iii) Name and address of doctor referred to:									

5) Does the patient have or ever have had any significant health conditions, medical history, any illness or any congenital condition? If "Yes", please advise: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Was the congenital condition mentioned in question 5) detected before birth? If yes, kindly specify the first symptom(s) and date of first symptom(s) presented (ddmmyyyy):	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Was the congenital condition mentioned in question 5) made known to his/her parents? If yes, please specify the date (ddmmyyyy):	<input type="checkbox"/> Yes <input type="checkbox"/> No
8) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5) above:	
9) Was any investigation/test performed to confirm the diagnosis of the congenital conditions stated in Question 5)? If yes, kindly provide copies of all relevant investigation report(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No
10) What is your source of the above information?	

C) Details of Illness											
1) Please provide details of the condition.											
(i) Date the patient First consulted you for the condition (ddmmyyyy):	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Details of symptom(s) presented at First consultation:											
(iii) Date of onset of these symptoms (ddmmyyyy):											
<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>											
(iv) Final Diagnosis of the condition:											
(v) ICD-10 Code:											
(vi) Date of First diagnosis (ddmmyyyy):	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										

(vii) Date the patient First became aware of the illness/condition (ddmmyyyy):	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
2) Was the patient born with absence of both arms (above the wrist), or both legs (above the ankle joints), or one arm (above wrist) and one leg (above the ankle joint) from birth? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please indicate which limb(s) is/are affected:									
3) What is/are the underlying cause(s) of the condition?									
4) Was this pregnancy conceived through any of the following fertility treatments:									
(i) Vitro Fertilization (IVF):	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(ii) Intra-Cytoplasmic Sperm (ICSI):	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(iii) Intrauterine Insemination (IUI):	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(iv) Intracervical Insemination (ICI):	<input type="checkbox"/> Yes <input type="checkbox"/> No								
If none of the above, please specify the fertility treatment that the patient has received:									
5) Was the patient's mother carrying 5 or more babies during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please indicate the number of babies that the patient has carried during the pregnancy:									
6) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state: Date of Diagnosis of AIDS/HIV (ddmmyyyy):									
<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
Date the patient First became aware of the condition (ddmmyyyy):									
<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
Please provide the details including name of doctor and hospital/clinic where the patient was First diagnosed with HIV or AIDS.									
Please provide a copy of relevant test result(s).									

7) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i) Self-inflicted illness, injury, suicide or attempted suicide? Yes No

(ii) Deliberate misuse of alcohol? Yes No

(iii) Deliberate misuse of drugs? Yes No

(i) Use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? Yes No

8) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by any complication resulting from fertility treatment(s)? Yes No

If "Yes", please specify the fertility treatment that the patient has received:

9) Is the patient still on follow-up at your hospital/clinic? Yes No

If "Yes", please state date of next appointment (ddmmyyyy):

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If "No", please state date of discharge (ddmmyyyy), if any:

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10) Please provide us with any other additional information that may assist the Company in assessing this claim.

Please enclose copies of all investigation reports including specialist, hospital and laboratory reports. Where applicable, please provide the following:

- (i) Computerised tomography scan (CT scan)
- (ii) Magnetic resonance imaging (MRI), other imaging studies
- (iii) Ultrasound reports
- (iv) X-Ray
- (v) Operation reports, surgical reports
- (vi) Referral letters (if any)
- (vii) Any other investigation reports

D) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor	Address & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	