* S U P D O C *

Singlife

Living Benefit Claim - Doctor's Statement
Congenital Illnesses Benefit – Cleft Lip and Cleft Palate

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) | | | | | | | | |

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): | | | | | | | | |

(ii) Date of **Last** consultation (ddmmyyyy): | | | | | | | | |

(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? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy): | | | | | | | | |

If "No", please provide name and address of the patient's regular doctor:

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please provide:

(i) Date referred (ddmmyyyy): | | | | | | | | |

(ii) Reason the patient was referred:

(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? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy): | | | | | | | | |

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

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5) Does the patient have or ever have had any significant health conditions, medical history, any illness or any congenital condition? ❒ Yes ❒ No

If "Yes", please advise:

Details of symptoms	Exact diagnosis	Date diagnosed	Treatment

6) Was the congenital condition mentioned in question 5) detected before birth? ❒ Yes ❒ No

If yes, kindly specify the first symptom(s) and date of first symptom(s) presented (ddmmyyyy):

7) Was the congenital condition mentioned in question 5) made known to his/her parents? ❒ Yes ❒ No

If yes, please specify the date (ddmmyyyy):

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)? ❒ Yes ❒ No

If yes, kindly provide copies of all relevant investigation report(s):

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): | | | | | | | | |

(ii) Details of symptom(s) presented at **First** consultation:

(iii) Date of onset of these symptoms (ddmmyyyy): | | | | | | | | |

(iv) **Final** Diagnosis of the condition:

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(v) ICD-10 Code:

(vi) Date of **First** diagnosis (ddmmyyyy):

(vii) Date the patient **First** became aware of the illness/condition (ddmmyyyy):

2) Has surgery been performed to correct the condition? ❒ Yes ❒ No

If "Yes", please provide date of surgery (ddmmyyyy) and provide a copy of the operation report:

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**): ❒ Yes ❒ No

(ii) Intra-Cytoplasmic Sperm (**ICSI**): ❒ Yes ❒ No

(iii) Intrauterine Insemination (**IUI**): ❒ Yes ❒ No

(iv) Intracervical Insemination (**ICI**): ❒ Yes ❒ 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? ❒ Yes ❒ No

If "No", please indicate the **number** of babies that the patient 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? ❒ Yes ❒ No

If "Yes", please state:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):

Date the patient **First** became aware of the condition (ddmmyyyy):

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).

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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 complications resulting from fertility treatments? ❒ 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): | | | | | | | | |

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

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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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