Living Benefit Claim - Doctor's Statement
Congenital Illnesses Benefit – Club Foot

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 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? ❒ 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) Please confirm if the following were present?

(i) Plantar Flexion: ❒ Yes ❒ No

(ii) Inversion of the heel hind foot and forefoot: ❒ Yes ❒ No

(iii) Adduction of forefoot: ❒ Yes ❒ No

3) Was the club foot bilateral? ❒ Yes ❒ No

4) Was there any surgery performed to correct the condition? ❒ Yes ❒ No

If "Yes", please provide the details of the surgery:

(i) Date of surgery performed (dd/mm/yyyy): | | | | | | | | |

(ii) Type of surgery performed. Please provide copy of the surgical report:

If "No" surgery has been performed, please state the treatment provided:

5) What is/are the underlying cause(s) of the condition?

6) 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:

7) 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.

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8) 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:

(i) Date of Diagnosis of AIDS/HIV (ddmmyyyy):

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

(iii) Please provide the details including name of doctor and clinic who first diagnosed the patient with HIV or AIDS.

Please provide a copy of relevant test result(s).

9) 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

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

10) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by any complication resulting from fertility treatments? ❒ Yes ❒ No

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

11) 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:

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12) 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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