Living Benefit Claim - Doctor's Statement
Congenital Illnesses Benefit – Congenital Diaphragmatic Hernia / Trancheo-esophageal Fistula or Esophageal Atresia

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 reason(s) 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 advise:
   - (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) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5) above.

7) 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:

(v) ICD-10 Code:

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

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

2) Was the patient diagnosed of **Diaphragmatic Hernia**? ❒ Yes ❒ No

If "No", please proceed to **Question 3)**.

(i) Was there presence of abdominal organs in the chest cavity at birth? ❒ Yes ❒ No

(ii) Was there finding of herniated abdominal content into the thorax in chest-radiograph or other Investigation reports? ❒ Yes ❒ No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy) | Test/Investigation reports | Results

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(iii) Was there surgical treatment undertaken for the treatment of Diaphragmatic Hernia? ❒ Yes ❒ No

If "Yes", please advise:

(a) Date of Operation (ddmmyyyy):

(iv) Was the Diaphragmatic Hernia associated with pulmonary hypoplasia? ❒ Yes ❒ No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy) | Test/Investigation reports | Results

(v) Was the Diaphragmatic Hernia associated with underdeveloped heart? ❒ Yes ❒ No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy) | Test/Investigation reports | Results

(vi) Was the Diaphragmatic Hernia detected during pregnancy period of patient's mother? ❒ Yes ❒ No

If "Yes", please advise:

(a) Date of Diaphragmatic Hernia detected during pregnancy period of patient's mother (ddmmyyyy):

(b) Date the patient's mother **First** became aware of Diaphragmatic Hernia detected during pregnancy period (ddmmyyyy):

3) Was the patient diagnosed of **Trancheo-esophageal Fistula**? ❒ Yes ❒ No

If "No", please proceed to **Question 4)**.

(i) Was there abnormal opening between the trachea and esophagus? ❒ Yes ❒ No

(ii) Was the Trancheo-esophageal Fistula supported by echocardiogram? ❒ Yes ❒ No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy) | Test/Investigation reports | Results

(iii) Was the Trancheo-esophageal Fistula a congenital disease? ❒ Yes ❒ No

If "No", please advise:

(a) What is/are the underlying cause(s)?

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(iv) Was there surgery done to correct Trancheo-esophageal Fistula? ❐ Yes ❐ No

If "Yes", please advise:

(a) Date of Operation (ddmmyyyy):

(v) Was the Trancheo-esophageal Fistula detected during pregnancy period of patient's mother? ❐ Yes ❐ No

If "Yes", please advise:

(a) Date of Trancheo-esophageal Fistula detected during pregnancy period of patient's mother (ddmmyyyy):

(b) Date the patient's mother **First** became aware of Trancheo-esophageal Fistula detected during pregnancy period (ddmmyyyy):

4) Was the patient diagnosed of **Esophageal Atresia**? ❐ Yes ❐ No

If "No", please proceed to **Question 5)**.

(i) Was there failure of the esophagus to develop as a continuous passage and it ends as a blind pouch? ❐ Yes ❐ No

(ii) Was the Esophageal Atresia supported by echocardiogram? ❐ Yes ❐ No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy)	Test/Investigation reports	Results

(iii) Was the Esophageal Atresia a congenital disease? ❐ Yes ❐ No

If "No", please advise:

(a) What is/are the underlying cause(s)?

(iv) Was there surgery done to correct Esophageal Atresia? ❐ Yes ❐ No

If "Yes", please advise:

(a) Date of Operation (ddmmyyyy):

(v) Was the Esophageal Atresia detected during pregnancy period of patient's mother? ❒ Yes ❒ No

If "Yes", please advise:

(a) Date of Esophageal Atresia detected during pregnancy period of patient's mother (ddmmyyyy):

(b) Date the patient's mother **First** became aware of Esophageal Atresia detected during pregnancy period (ddmmyyyy):

5) 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:

6) Was the patient's mother carrying 5 or more babies in this pregnancy? ❒ Yes ❒ No

If "No", please state the **number** of babies that the patient has carried in this single pregnancy.

7) 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 provide:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):

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

If "Yes", please provide the details including name of doctor and clinic who first diagnosed the patient with HIV or AIDS, Please provide copy of test result.

8) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by:

(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

9) 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:

10) 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.

11) 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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