Disability Income and/or Total & Permanent Disability and/or Terminal Illness Claim - Doctor's Statement

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

A) Patient's Particulars		
Name of Patient	Gender	Occupation
NRIC/FIN or Passport 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:

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc.)? ❒ 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?

8) Please give details of the patient's past and present **smoking** habits, including the duration of smoking habit(s), number of cigarettes smoked per day and source of this information.

No. of years of smoking	No. of sticks per day	Source of information

9) Please give details of the patient's **alcohol consumption** habits, including the amount of the alcohol consumption, frequency, and the source of this information.

Type of alcohol	Quantity per Consumption	Frequency (per week / month, etc)	Source of information

C) Details of Disability / Illness

1) Please provide details of the disability/illness:

(i) Date the patient **First** consulted for the condition (ddmmyyyy): | | | | | | | | |

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

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

(iv) What is/are the underlying cause(s) of the symptoms?

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

(vi) ICD-10 Code:

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

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

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

2) What were the **physical** disability and limitation(s) presented during the **Last** consultation?

3) What were the **mental** disability and limitation(s) presented during the **Last** consultation?

4) Please state your assessment of the patient's limb power:

Date of Assessment (ddmmyyyy)		**Limb Power**		**Limb Power**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

5) Please state your assessment of the patient's power grip and precision grip:

Date of Assessment (ddmmyyyy)		**Power Grip**		**Power Grip**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

Date of Assessment (ddmmyyyy)		**Precision Grip**		**Precision Grip**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

6) Please provide full details and results of all **investigations** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports.

7) Name and address of the doctor who **First** diagnosed the patient with this condition.

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

8) Is the condition a result of a bodily injury caused solely by an **Accident**? ❒ Yes ❒ No

If 'No", please proceed to Question 9.

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy): | | | | | | | | |

(ii) Time of Accident: | | a.m. / p.m.

(iii) Place of Accident:

(iv) Describe in detail how the accident happened:

(v) Describe the extent and severity of the bodily injuries/disability sustained, including the exact site(s) of the body affected:

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division Name of Police Officer-in-charge

(vii) Was the patient under the influence of alcohol and/or drug(s) at the time of accident? ❒ Yes ❒ No
If "Yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test; name of drug(s), quantity consumed, etc.):

9) Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation(s).

10) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitation, including the degree of cognitive and/or intellectual impairment.

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

11) (i) Is the patient mentally incapacitated? ❒ Yes ❒ No

(ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

12) If any treatment(s) has/have been prescribed to the patient, please describe and elaborate in detail including number of cycles, commencement date and termination date:

(i) Medical aids

(ii) Medical therapy

(iii) Operation performed

(iv) Occupational therapy

(v) Rehabilitation programs (e.g. physiotherapy)

(vi) Training courses

(vii) Workplace modification

(viii) Others treatments

13) What is the name of the doctor(s) and hospital/clinic where the patient received and/or is receiving the abovementioned treatment?

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

14) What was the patient's response to the treatment?

15) Has the patient's condition improved, deteriorated, or remained static? (Please circle as applicable)

(i) Since the disability commenced? Improved / Deteriorated / Remained static

(ii) Since the six (6) months prior to the **Last** consultation**?** Improved / Deteriorated / Remained static

16) If recovery can be reasonably expected, please describe the extent of possible recovery in the next:

(i) Three (3) to six (6) months:

(ii) Six (6) to twelve (12) months:

17) Please advise:

Patient's occupation **just before** the disability	Patient's nature of job duties **just before** the disability

18) Based on the **Last** consultation, has the disability prevented the patient from performing all the normal duties of **his/her usual occupation**? ❒ Yes ❒ No

If "No", when is the patient expected to return to his/her usual occupation? (ddmmyyyy)

If "Yes", please advise:

(i) To what extent does the patient's disability prevent him/her from performing **his/her usual occupation**?

(ii) Date that the patient first became unable to perform all the normal duties of his/her usual occupation (ddmmyyyy):

Please also attach a **detailed report** giving all findings relevant to the case and the reasons to support.

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

19) Based on the **Last** consultation, has the disability prevented the patient from performing **any work, occupation or profession** that the patient can ever sufficiently do or follow to earn or obtain any wages, compensation or profits?

❒ Yes ❒ No

If "No", please advise:

(i) What type of occupation and job duties can the patient perform?

(ii) What is/are the limitation(s)?

(iii) Date that the patient is expected to return to any work, occupation or profession (ddmmyyyy): | | | | | | | | |

If "Yes", please advise:

(i) Is the disability total and permanent? ❒ Yes ❒ No

(ii) Is the disability beyond any hope of recovery? ❒ Yes ❒ No

(iii) To what extent does the patient's disability prevent the patient from doing **any work, occupation, or profession**?

(iv) Initial date that the patient cannot perform any work, occupation, or profession (ddmmyyyy): | | | | | | | | |

Please also attach a **detailed report** giving all findings relevant to the case the reasons to support.

20) Based on the **Last** consultation**,** is the patient suffering from total and irrecoverable:

i) Loss of the sight of both eyes? ❒ Yes ❒ No
If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

ii) Loss of sight of one (1) eye and loss by severance or loss of use of one (1) limb or above the ankle or wrist? ❒ Yes ❒ No
If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

iii) Loss by severance or loss of use of both hands at or above the wrist? ❒ Yes ❒ No
If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

iv) Loss by severance or loss of use of both feet at or above the ankles? ❒ Yes ❒ No
If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

v) Loss by severance or loss of use of one (1) hand at or above the wrist and one (1) foot at or above the ankle? ❒ Yes ❒ No
If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

21) Is the patient confined to a home, hospital or other institution that provides constant care and medical attention? ❒ Yes ❒ No

If "Yes", please state the start date of confinement (dmmyyyy):

Name and address where the patient is residing now:

22) Have active treatment and therapy been rejected in favour of the relief of symptoms? ❒ Yes ❒ No

If "Yes", please provide full details and explain the reason for this course of action.

23) Based on the **Last** consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:

(i) Six (6) months? ❒ Yes ❒ No

(ii) Twelve (12) months? ❒ Yes ❒ No

If "Yes" to (i) and/or (ii), please advise:

a) Medical treatment(s) that had been provided to the patient:

b) Prognosis after undergoing the mentioned medical treatment(s):

c) Any other details on the basis of your evaluation:

24) Is the patient's 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 advise:

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 the relevant test result(s).

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

25) Is the patient's diagnosis/disability directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i)	Self-inflicted injury?	❒ Yes	❒ No
(ii)	Suicide?	❒ Yes	❒ No
(iii)	Wilful misuse of alcohol?	❒ Yes	❒ No
(iv)	Wilful misuse of drugs?	❒ Yes	❒ No
(v)	Congenital anomaly or defect?	❒ Yes	❒ No

If "Yes", please provide full details including reasons for the self-inflicted injury, suicide, result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and hospital/clinic where the patient was **First** diagnosed with self-inflicted injury, suicide, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

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

D) Additional Information

1) Based on the **Last consultation mentioned on Section B 1ii) above**, please **circle** as applicable in relation to the patient's ability to perform the Activities of Daily Living (ADLs), **whether aided or unaided** by special equipment, device and/or apparatus (and not pertaining to human aid).

Definition of ADL	Extent of Independence	Yes / No	If patient <u>always requires</u> another person's help, please state the followings:
Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. • Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons _____ _____ (b) Date of disability **First** occurred (ddmmyyyy) ☐☐☐☐☐☐☐☐ (c) For how long has he/she been continuously unable to do so? _____
Dressing: The ability to put on, take off, secure, and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. • Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons _____ _____ (b) Date of disability **First** occurred (ddmmyyyy) ☐☐☐☐☐☐☐☐ (c) For how long has he/she been continuously unable to do so? _____

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. • Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons _____ _____ (b) Date of disability **First** occurred (ddmmyyyy) ☐☐☐☐☐☐☐☐ (c) For how long has he/she been continuously unable to do so? _____
Mobility: The ability to move indoors from room to room on level surfaces.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. • Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons _____ _____ (b) Date of disability **First** occurred (ddmmyyyy) ☐☐☐☐☐☐☐☐ (c) For how long has he/she been continuously unable to do so? _____
Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions to maintain a satisfactory level of personal hygiene.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. • Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons _____ _____ (b) Date of disability **First** occurred (ddmmyyyy) ☐☐☐☐☐☐☐☐ (c) For how long has he/she been continuously unable to do so? _____
Feeding: The ability to feed oneself once food has been prepared and made available.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. • Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons _____ _____ (b) Date of disability **First** occurred (ddmmyyyy) ☐☐☐☐☐☐☐☐ (c) For how long has he/she been continuously unable to do so? _____

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

2) Please indicate which ADLs the patient requires the physical assistance of another person for **more than 74% of the time** in performing each activity, **even with** the use of **adaptive equipment**.

Please tick	Activities of Daily Living (ADLs)	Please tick	Activities of Daily Living (ADLs)
	Washing/Bathing		Mobility
	Dressing		Toileting
	Transferring		Feeding

Please elaborate how you arrive at the assessment.

3) What tests or assessments were used to evaluate the patient's functional ability for each of the ADLs mentioned above (e.g. standardised functional assessments, observation of patient performing ADL-specific tasks etc.)?

4) If your assessment of the patient's functional ability for any of the ADLs was based on report(s) provided by the patient or their relatives, please attach a copy of the relevant report(s).

5) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient has consulted for for the **condition or any other related diseases**? ❒ Yes ❒ No

If "Yes", please advise:

Name of doctor and Address of hospital/clinic	Date **First** & **Last** consulted	Reasons for consultation

6) Are further investigations planned? ❒ Yes ❒ No

If "Yes", please elaborate:

If "No", please give reason(s):

7) What is your recommendation for the patient's future case management, including any proposed rehabilitation program or surgeries?

8) 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: | | | | | | | | |

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

9) 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) X-Ray
(iv) Operation reports, surgical reports
(v) Referral letters (if any)
(vi) Any other investigation reports

E) 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)	

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8