* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Loss of Independent Existence / Loss of Independent Existence (Early Stage) / Loss of Independent Existence (Intermediate Stage)

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, overweight, etc.) If "Yes", please advise: ❒ Yes ❒ No

Details of symptoms	Exact diagnosis	Date diagnosed	Treatments

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 provide details of the patient's past and present **smoking** habits, including the duration of smoking habits, 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 provide 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 current Disability/Illness:

(i) Date of **First** consultation for the current condition (ddmmyyyy):

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

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

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

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

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

(vi) ICD-10 Code:

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

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

2) Name and address of the doctor who **First** diagnosed the patient with the condition:

3) 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.

4) Was the condition a result of an **Accident**? ❒ Yes ❒ No

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 exact site(s) of the body:

(vi) Was the accident reported to the police? ❒ Yes ❒ No
If "No", why not?

If "Yes", please provide the following information and **attach** a copy of the police report.
Police Division Name of Police Officer-in-charge

(vii) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits)? ❒ Yes ❒ No
If "Yes", please provide full details.

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

5) (i) Please state the limb(s) involved and the extent of loss of use:

Specific limb	**Extent of loss of use (if applicable)**	**Is extent of loss of use above the elbow? (circle as appropriate)**	**Is extent of loss of use above the knee? (circle as appropriate)**	**Is the loss of use total and irreversible? (circle as appropriate)**
Left upper limb		Yes / No	Yes / No	Yes / No
Left lower limb		Yes / No	Yes / No	Yes / No
All fingers **including** thumb at left upper limb		Yes / No	Yes / No	Yes / No
Right upper limb		Yes / No	Yes / No	Yes / No
Right lower limb		Yes / No	Yes / No	Yes / No
All fingers **including** thumb at right upper limb		Yes / No	Yes / No	Yes / No

(ii) If the loss of use of the involved limb(s) is total and irreversible, please advise:

The basis of the assessment

First date of such continuous loss of use

(iii) Please advise if the paralysis or loss of use of limb(s) has persisted for at least 6 weeks? ❒ Yes ❒ No

If "Yes", please advise:

Date of initial episode (ddmmyyyy):

(iv) Please advise if the patient underwent fitting and use of prosthesis to the affected limb(s)? ❒ Yes ❒ No

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

6) 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	

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

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

8) Please provide in detail the **treatment** prescribed with **dates**, including type of operation performed, rehabilitation programs (e.g. physiotherapy – number of cycles, commencement and termination date), medication, any surgery contemplated, etc:

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

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

11) Please tick in the relevant box below whether the patient's condition is likely to:

(i) Improve ❒ or Deteriorate ❒ or Remain static ❒

If "Improve", please advise:

a) The extent of improvement expected:

b) Estimated date of recovery (dd/mm/yyyy): | | | | | | | | |

If "Deteriorate" or "Remain static", please elaborate with reasons on how you arrive at the opinion:

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

12) Was the patient admitted at the hospital for treatment of the diagnosis? ❒ Yes ❒ No

If "Yes", please advise:

Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		
Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		

13) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the diagnosis? ❒ Yes ❒ No

If "Yes", please advise:

Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		
Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		

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

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

(i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please provide details:

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

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

(ii) Wilful misuse of alcohol? ❒ Yes ❒ No

(iii) Wilful misuse of drugs? ❒ Yes ❒ No

(iv) Congenital anomaly or defect? ❒ Yes ❒ No

(v) Self-inflicted act? ❒ Yes ❒ No

If "Yes", please provide full details including reasons for the self-inflicted act, 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 HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs, congenital anomaly or defect or self-inflicted act.

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? _____

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

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? _____
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? _____

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

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? _____

2) Which 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.)?

3) If your assessment of the patient's function for each of the ADLs was taken from report(s) provided by the patient or relatives, please attach a copy of the relevant report(s).

4) Is the inability to perform aided* or unaided activity of daily living due to **non-organic diseases** such as

(i) Neurosis? ❒ Yes ❒ No

(ii) Psychiatric illnesses? ❒ Yes ❒ No

If "Yes", please provide full details:

* "Aided" refers to the assistance of special equipment, device and/or apparatus and not pertaining to human aid.

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

If "Yes", since what date? (ddmmyyyy): ☐☐☐☐☐☐☐☐

Name and address where the patient is residing now:

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

6) Is there anything in the patient's **lifestyle** or **personal medical history** that may have increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please advise:

Type of Lifestyle/Exact diagnosis	Date of diagnosis	Name of doctor & address of hospital/clinic

7) Is there anything in the patient's **family history** that mayhave increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please advise:

Relationship with patient	Nature of condition	Age of onset	Source of information

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

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

9) 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:

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

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

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

12) (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

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

If "Yes", please advise:

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

14) 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: | | | | | | | | |

15) 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, hospitaland laboratory reports. Where applicable, please include 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