Critical Illness Claim - Doctor's Statement
Irreversible Loss of Speech / Permanent (or Temporary) Tracheostomy / Irreversible Loss of Speech due to neurological disease

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

A) Patient's Particulars	
Name of Patient	Gender
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 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 or any illness (e.g. cyst, 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 habits 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 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 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 during the **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:

(vii) Date of **First** Diagnosis (ddmmyyyy) ☐☐☐☐☐☐☐☐

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(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) Is the loss of speech as a resultf of injury *or* disease of the vocal cord? ❒ Yes ❒ No
If "Yes", please provide details:
(i) Injury to vocal cord:

(ii) Disease of vocal cord:

5) Is the loss of speech contributed by or associated with
(i) any neurological related causes? ❒ Yes ❒ No
(ii) any psychiatric related causes? ❒ Yes ❒ No
If "Yes" to the above, please provide details on the date of diagnosis, exact diagnosis and name and address of attending doctor.

6) Is the patient currently undergoing any speech therapy sessions? ❒ Yes ❒ No
If "Yes", please advise:
Frequency [ ] Duration [ ]
If "No", please state date of **Last** speech therapy session (ddmmyyyy) | | | | | | | | |
Has there been any improvement in the patient's speech since onset of the condition? ❒ Yes ❒ No
If "No", please elaborate.

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7) Name and address of attending doctor where the sessions were done.

8) Is the loss of speech total and irrecoverable/irreversible? ❐ Yes ❐ No

If "Yes", please provide details of the investigation performed to confirm the loss is total and irrecoverable/irreversible.

Please attach a copy of diagostic test reports (e.g. fiberoptic nasolaryngoscopy, etc.)

9) Will any surgery improve or could reinstate patient's ability to speak? ❐ Yes ❐ No

If "Yes", please advise:

(i) Name of Surgery

(ii) Date of Operation (ddmmyyyy)

10) Has a Tracheostomy been performed? ❐ Yes ❐ No

If "Yes", please advise:

(i) Date of Operation (ddmmyyyy)

(ii) Was the Tracheostomy done for treatment of lung disease or airway disease or as a ventilatory support measure following major trauma or burns? ❐ Yes ❐ No

If "Yes", please provide details.

(iii) Was the Tracheostomy done for the purpose of saving life? ❐ Yes ❐ No

If "Yes", please provide details.

(iv) Was the Tracheostomy tube remained in place and functional for a period of three (3) months? ❐ Yes ❐ No

If "Yes", please advise:

Date of Removal of the Tracheostomy tube (ddmmyyyy)

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11) Has the inability to speak lasted for a continuous period of 12 months? ❒ Yes ❒ No

If "Yes", please state the period the patient has been continously unable to speak.
Months

12) Was the patient admitted to a 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)		

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

(i) 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)								

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

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

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

If "Yes", please provide full details including reasons for the 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 or congenital anomaly or defect.

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

D) Other Information

1) What is the prognosis of the patient's condition?

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

If "Yes", please advise:

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

3) Is there anything in the patient's **family history** that may have increased the risk of this condition?

❒ Yes ❒ No

If "Yes", please advise:

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

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4) 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.

5) 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.

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

7) 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.

8) (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

9) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **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

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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) Nasopharyngoscopy reports
(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)	

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