* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Severe Encephalitis / Encephalitis

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 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, 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 provide details of the patient's past and present **smoking** habit(s), 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 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) 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) Is the Encephalitis caused by viral infection? ❒ Yes ❒ No

If "No", please indicate the underlying cause of the condition.

If "Yes", was any appropriate investigation (including Lumbar puncture test) performed to prove the acute viral infection of the brain? ❒ Yes ❒ No

Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of all relevant test reports.

3) Is there any severe inflammation of the brain substance (cerebral hemisphere, brainstem, or cerebellum)? ❒ Yes ❒ No

If "Yes", was any appropriate investigation (including Lumbar puncture test) performed to prove the severe inflammation of the brain substance (cerebral hemisphere, brainstem, or cerebellum)? ❒ Yes ❒ No

Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of all relevant test reports.

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

4) Please describe in full details (with dates) the extent of neurological deficits.

Date of initial episode (ddmmyyyy)	Types of neurological deficits experienced	Duration of symptoms

5) Was there any permanent neurological deficit lasting for at least six (6) weeks after the initial episode? ❒ Yes ❒ No

If "Yes", please provide details on the permanent neurological deficit with persisting clinical symptoms which indicates symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the patient:

Please tick	**Neurological deficit**	**Date of last review confirming the neurological deficit (ddmmyyyy)**	**Please specify the exact body part(s) affected**	**Is the neurological deficit permanent and expected to last throughout the lifetime?**	**Please elaborate with supporting evidence**
	Numbness			Yes / No	
	Paralysis			Yes / No	
	Localised weakness			Yes / No	
	Dysarthria (difficulty with speech)			Yes / No	
	Aphasia (inability to speak)			Yes / No	
	Dysphagia (difficulty swallowing)			Yes / No	
	Visual Impairment			Yes / No	
	Difficulty in walking			Yes / No	
	Lack of coordination			Yes / No	
	Tremor			Yes / No	
	Seizures			Yes / No	
	Dementia			Yes / No	
	Delirium			Yes / No	
	Coma			Yes / No	
	Others, please specify:			Yes / No	

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

6) Please provide full details and results of all **investigation** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports including **Brain MRI, culture of cerebrospinal fluid (CSF), electroencephalogram etc.**

7) Name and address of the **neurologist** who **First** diagnosed the patient with the condition:

8) Please provide details of ongoing **treatment**, including any physical and/or speech therapy, if any.

9) 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)		

10) 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

11) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed by any of the following?

(i) Human Immunodeficiency Virus (HIV) infection? ❒ Yes ❒ No

(ii) 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): | | | | | | | | |

If "Yes", please provide the details including name of doctor and hospital/clinic who **First** diagnosed the patient with HIV or AIDS.

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

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

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

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

(iii) 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** t with 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 the condition? ❒ Yes ❒ No

If "Yes", please advise:

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

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

4) 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

5) 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.

6) 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 relevant details forming on the basis of your evaluation:

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

8) 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.

9) (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

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

10) 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

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: | | | | | | | | |

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, hospitaland laboratory reports. Where applicable, please include the following:

(i) Blood test reports
(ii) Cerebrospinal fluid analysis result reports
(iii) Computerised tomography scan (CT scan)
(iv) Magnetic resonance imaging (MRI), other imaging studies
(v) X-Ray
(vi) Operation reports, surgical reports
(vii) Referral letters (if any)
(viii) 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