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an NTUC Social Enterprise

Attending Medical Practitioner's Statement

Part 1 (To be completed by Insured)

Name of Insured (as shown in NRIC)		NRIC number
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number

Declaration and Authorisation
1. I confirm that I have agreed to the "Personal Data Collection Statement" provided in the Medical/Accident/Living/Total & Permanent Disability claim form.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner to release to Income any information as requested by Income; and
   (b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner.

A photocopy of this form is valid as an original copy.

Signature/Thumbprint of Insured/next-of-kin[1] _____ Date (dd/mm/yyyy) _____

[1] Please delete accordingly

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC number

Height of Insured _____ m Weight of Insured _____ kg

The above readings were taken on this date (dd/mm/yyyy) _____ /_____ /_____

1. (a) Are you the Insured's usual doctor?	☐ Yes ☐ No
(b) Over what period do your records extend? Start date (dd/mm/yyyy) _____ /_____ /_____ End date (dd/mm/yyyy) _____ /_____ /_____	
2. What is the diagnosis for the Insured's present illness/injury?	
(a) What is the exact date of diagnosis? (dd/mm/yyyy) _____ /_____ /_____	
(b) Please provide us the name and address of the doctor where the diagnosis was first made.	
(c) Was the Insured informed of the diagnosis? If "Yes", when was he first informed? (dd/mm/yyyy) _____ /_____ /_____	☐ Yes ☐ No
(d) Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details.	☐ Yes ☐ No
3. (a) Was the condition caused by an accident? If "Yes", please state: Accident date (dd/mm/yyyy) _____ /_____ /_____ Accident time _____	☐ Yes ☐ No
(b) Describe the accident.	

Part 2 (To be completed by Doctor) (continued)

(c) Was the accident reported to the police?	☐ Yes ☐ No
(d) Was the Insured under the influence of alcohol/drugs at the time of accident? If "Yes", please state the blood alcohol content/drug type and quantity consumed.	☐ Yes ☐ No
(e) Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details.	☐ Yes ☐ No

4. Please provide details of the symptoms presented when you first saw the Insured.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

5. Was the Insured referred to you by another doctor? If "Yes", please provide details. ☐ Yes ☐ No

Name of referring doctor	Name and address of clinic/hospital	Date Insured consulted referring doctor (dd/mm/yyyy)	Reason(s) for the referral

6. Did the Insured see any other doctor(s) besides those indicated above? If "Yes", please provide details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

7. What were the investigations done to confirm the diagnosis?

Please also enclose copies of all reports used in the management of the Insured's condition(s), e.g. biopsy reports, cytology and histopathology reports, x-rays, CT and MRI scans, other imaging studies, laboratory reports, surgical reports, rehabilitation and occupational therapy report, and other relevant reports.

8. (a) Please provide details of treatment that has been provided (e.g. surgery, chemotherapy, radiotherapy, physiotherapy, etc.).

Type of treatment	Date of treatment (dd/mm/yyyy)	Duration of treatment	Response to treatment

Part 2 (To be completed by Doctor) (continued)

(b) Has the Insured been compliant with the treatment suggested? If "No", please provide details. ☐ Yes ☐ No

(c) Are there plans for other forms of treatment? If "Yes", please provide full details. ☐ Yes ☐ No

Type of treatment	Expected date of treatment (dd/mm/yyyy)	Expected response to treatment

(d) Has the Insured rejected any treatment that would improve his current condition? If "Yes", please provide us the following: ☐ Yes ☐ No

(i) Type(s) of treatment that would improve Insured's condition

(ii) How would the treatment improve Insured's condition and to what extent?

(iii) Why did Insured reject the treatment?

9. What is the prognosis of the Insured's condition? ☐ Improve ☐ Deteriorate ☐ Remain unchanged

(a) Please describe the nature and severity of the Insured's condition.

(b) Is full recovery expected? ☐ Yes ☐ No

If "Yes", please state approximate date (dd/mm/yyyy) _____ /_____ /_____

If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) _____ /_____ /_____

(c) At your last assessment, does the Insured have any deficits pertaining to his general motor functions? If "Yes", please provide details in (i) to (iv). ☐ Yes ☐ No

Date of last assessment (dd/mm/yyyy) _____ /_____ /_____

(i) Range and strength (please indicate power grading of limbs)

(ii) Gait and balance

(iii) Coordination

Part 2 (To be completed by Doctor) (continued)

(iv) Movement

(d) Are there any neurological deficits pertaining to the Insured's sensory functions, or other aspects like hearing, smell, visual? If "Yes", please provide details.	☐ Yes ☐ No

10. (a) Please tick as applicable in relation to the Insured's ability to perform the Activities of Daily Living, whether aided with special equipment or unaided.

Activity	Need someone to help throughout the entire activity	Period which help was required	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
Washing or bathing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	☐ Yes ☐ No		
Dressing Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs, or other surgical appliances.	☐ Yes ☐ No		
Feeding Ability to feed oneself once food has been prepared and made available.	☐ Yes ☐ No		
Toileting Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	☐ Yes ☐ No		
Transferring Ability to move from a bed to an upright chair or wheelchair and vice versa.	☐ Yes ☐ No		
Mobility Ability to move indoors from room to room on level surfaces.	☐ Yes ☐ No		

(b) Is the Insured confined to a home/hospital/or other institution which provides continuous care and medical attention? If "Yes", please provide name and address of this institution, and period(s) of confinement (dd/mm/yyyy).	☐ Yes ☐ No

11. What was the Insured's occupation before his disability?

(a) What was the nature of his duties?

(b) Does the Insured's disability prevent him from performing the above listed duties? If "Yes", please state why.	☐ Yes ☐ No
12. (a) Has the Insured returned to his usual occupation?	☐ Yes ☐ No

(b) If "No", would the Insured be able to return to his usual occupation at a later date?

☐ Not able to determine presently (Go straight to Question 14)

☐ Yes – Expected date of return to his usual occupation is (dd/mm/yyyy) _____ /_____ /_____

☐ No – Not possible to return to usual occupation even at a later date

Part 2 (To be completed by Doctor) (continued)

13. If the Insured cannot return to his usual occupation even at a later date because of his condition, is there any other suitable occupation(s), including sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.) that he can consider in the future?

☐ Yes Examples of such occupation(s) are: _____
Expected date when his condition allows him to engage in these occupation(s) is:

(dd/mm/yyyy) _____ /_____ /_____

☐ No The Insured is unable to take part in <u>any paid work for the rest of his life.</u>
Please provide us with reason (s) for your answer.
Reason (s):

_____

_____

_____

_____

_____

Please state the date when the Insured was considered not able to take part in any paid work for the rest of his life.

(dd/mm/yyyy) _____ /_____ /_____

14. If the extent of the Insured's disability cannot be determined at this moment, when would be an appropriate date to assess it?

(dd/mm/yyyy) _____ /_____ /_____

15. Please tick (✓) and answer all applicable sections. Where not applicable, please indicate 'N.A.'

(a) Total and permanent loss of sight
The loss must be permanent and irreversible, even with the use of visual aids.

☐ Right eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

☐ Left eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

Please describe the nature and cause of total and permanent loss of sight.

_____

_____

_____

_____

_____

Part 2 (To be completed by Doctor) (continued)

(b) Severance of limbs/total loss of use of limbs

☐ Severance of upper limbs

	Left upper limb	Date (dd/mm/yyyy)	Right upper limb	Date (dd/mm/yyyy)
Severance at or above wrist	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above elbow	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

_____

_____

☐ Severance of lower limbs

	Left lower limb	Date (dd/mm/yyyy)	Right lower limb	Date (dd/mm/yyyy)
Severance at or above ankle	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above knee	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: _____)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

_____

_____

☐ Total loss of use (defined as total and permanent loss of physical function)

	Date of commencement of loss of use (dd/mm/yyyy)	Please describe the nature and cause of total loss of use
Left upper limb		
Left lower limb		
Right upper limb		
Right lower limb		

Please describe the nature and cause of severance.

_____

_____

Part 2 (To be completed by Doctor) (continued)

16. (a) Please describe the Insured's mental and cognitive abilities.

(b) Is the Insured mentally incapacitated in accordance to the Mental Capacity Act? ☐ Yes ☐ No

(c) If "Yes" to Question 16b above, please state the date when the mental incapacity started.

Date of last assessment (dd/mm/yyyy) _____ /_____ /_____

17. Is the Insured suffering or has suffered from any other disease or ailment? If "Yes", please provide full details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

18. Is the Insured terminally ill, i.e. death is expected within 12 months? If "Yes", please provide details on the basis of your evaluation. ☐ Yes ☐ No

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) _____ /_____ /_____

19. Please provide us with any other information that will be helpful in the assessment of this claim.

_____ _____

Signature of doctor | Date (dd/mm/yyyy)

_____ _____

Name and qualification (printed) | Address and official stamp of clinic/hospital