

## 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
<p><b>Declaration and Authorisation</b></p> <p>1. I confirm that I have agreed to the "Personal data use statement" provided in the Medical/Accident/Living/Total &amp; Permanent Disability claim form.</p> <p>2. I agree and authorise:</p> <p style="margin-left: 20px;">(a) Any medical institution or medical practitioner to release to Income any information as requested by Income; and</p> <p style="margin-left: 20px;">(b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner.</p> <p>A photocopy of this form is valid as an original copy.</p>		
_____ Signature/Thumbprint of Insured/next-of-kin <sup>1</sup>		_____ Date (dd/mm/yyyy)

<sup>1</sup> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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) _____ / _____ / _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details.		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. (a) Was the condition caused by an accident? If "Yes", please state:  Accident date (dd/mm/yyyy) _____ / _____ / _____      Accident time _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Describe the accident.		

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

(c) Was the accident reported to the police?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.		<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Are there plans for other forms of treatment? If "Yes", please provide full details.		<input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Improve <input type="checkbox"/> Deteriorate <input type="checkbox"/> Remain unchanged		
(a) Please describe the nature and severity of the Insured's condition.		
(b) Is full recovery expected?  If "Yes", please state approximate date (dd/mm/yyyy) _____ / _____ / _____  If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) _____ / _____ / _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(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).  Date of last assessment (dd/mm/yyyy) _____ / _____ / _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
(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)
<b>Washing or bathing</b> Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Dressing</b> Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs, or other surgical appliances.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Feeding</b> Ability to feed oneself once food has been prepared and made available.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Toileting</b> Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Transferring</b> Ability to move from a bed to an upright chair or wheelchair and vice versa.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Mobility</b> Ability to move indoors from room to room on level surfaces.	<input type="checkbox"/> Yes <input type="checkbox"/> 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 any paid work for the rest of his life.  
 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	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Severance at or above elbow	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Others (please specify: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please describe the nature and cause of severance.

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Severance of lower limbs

	Left lower limb	Date (dd/mm/yyyy)	Right lower limb	Date (dd/mm/yyyy)
Severance at or above ankle	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Severance at or above knee	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Others (please specify: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please describe the nature and cause of severance.

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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.

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**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.

<p align="center">_____ Signature of doctor</p>	<p align="center">_____ Date (dd/mm/yyyy)</p>
<p align="center">_____ Name and qualification (printed)</p>	<p align="center">_____ Address and official stamp of clinic/hospital</p>