* S U P D O C *

Singlife

Personal Accident Claim - Doctor's Statement

SECTION 2 – 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) No. of consultations during the above period:

(iv) Name of hospital/clinic and reason(s) of 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 of referral (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 of referral (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. bodily impairments or disability, hepatitis, diabetes, hypertension, hyperlipidaemia, etc.) ❒ Yes ❒ No

If "Yes", please advise:

Details of symptoms	Exact Diagnosis	Date Diagnosed	Treatment

6) Please provide the name and address of the 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 habit(s), 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

10) Is the patient being taken care by a caregiver at the hospitalisation? ❒ Yes ❒ No

If "Yes", please advise:

(i) Relationship to the patient:

(ii) Name of the caregiver:

(iii) Areas of the patient's daily activities assisted by the caregiver

C) Details of Illness / Accident

1) Is the condition due to an Illness or an Accident? Please tick (√). ❒ Illness ❒ Accident

2) (i) Date of Accident (ddmmyyyy): | | | | | | | | |

(ii) Please describe how the accident occurred.

(iii) Please describe the extent and severity of injury sustained, including the anatomical site involved.

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3) Please provide details of the condition:

(i) Date the patient **First** consulted for the condition (ddmmyyyy): | | | | | | | | |

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

4) Was there any bodily injury? ❒ Yes ❒ No

If "Yes", please advise:

(i) Was the bodily injury caused solely by the **Accident mentioned in Question 2)**? ❒ Yes ❒ No

(ii) What was the bodily injury sustained?

5) What is/are the underlying cause(s) of the illness or injury?

6) Were there any underlying illnesses or conditions that contributed to the accident or injury? ❒ Yes ❒ No

If "Yes", please advise:

(i) Full details of the condition

(ii) How it contributed to the accident or injury?

7) (i) **Final** Diagnosis:

(ii) ICD-10 Code:

(iii) Date of **First** Diagnosis (ddmmyyyy): | | | | | | | | |

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

8) Name and address of hospital / clinic at which the patient was treated and/or admitted.

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9) Was the patient admitted to a hospital for treatment of the condition? ❒ Yes ❒ No

If "Yes", please advise:

	Hospitalisation Period (including Intensive Care Unit (ICU))		**Hospitalisation Period in Intensive Care Unit (ICU)**	
Name of the hospital	Admission Date (ddmmyyyy)	Discharge Date (ddmmyyyy)	Admission to ICU (ddmmyyyy)	Discharge from ICU (ddmmyyyy)

10) Were any surgical procedures performed on the patient? ❒ Yes ❒ No

If "Yes", please provide full details of the surgical operation(s) performed:

Please attach a copy of the operation report(s).

11) Please state the objective(s) of the operation(s).

12) If two (2) or more of the surgical procedures were performed, were they performed under the same anaesthesia? ❒ Yes ❒ No

If "No", please provide details:

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13) Please state the date of surgery (ddmmyyyy) and attach a copy of the operation report(s).

14) Is patient still under your care for the condition? ❒ Yes ❒ No

If "No", please state date of **Last** consultation (ddmmyyyy)

15) If no surgery was performed, was surgery advised? ❒ Yes ❒ No

If "Yes", please provide the reason(s) why the patient did not proceed with the surgery:

16) Please provide the period of medical leave granted to the patient:

i) **Temporary Total Disability** (ddmmyyyy)
- Totally and continuously disabled on a temporary basis and prevented from performing <u>each and every duty</u> pertaining to the patient's condition

From:

To:

ii) **Temporary Partial Disability** (ddmmyyyy)
- Partially and continuously disabled on a temporary basis and prevented from performing <u>one or more duties</u> pertaining to the patient's condition

From:

To:

17) When is the patient expected to recover? (ddmmyyyy)

18) Based on the **Last** consultation, if recovery is not reasonably expected, is the disability:

a) Total and Permanent, such that there is neither then nor at any time thereafter any work, occupation or profession that the patient can ever sufficiently do or follow to earn or obtain any wages, compensation or profits? ❒ Yes ❒ No

b) Beyond any hope of recovery? ❒ Yes ❒ No

If "Yes", please advise:

i) Start date of disability (ddmmyyy):

ii) Basis of your evaluation.

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19) a) Based on the **Last** consultation, has the disability prevented the patient from performing all the normal duties of **his/her usual occupation**? ❒ Yes ❒ No

If "No", when is the patient expected to return to his/her usual occupation? (ddmmyyyy) | | | | | | | | |

If "Yes", please advise:

(i) The extent to which the disability prevents the patient from doing **his/her usual occupation**?

(ii) The initial date the patient became unable to perform all the normal duties of his/her usual occupation (ddmmyyyy): | | | | | | | | |

Please also attach a **detailed report** including all relevant findings and the reasons to support.

b) Based on the **Last** consultation, has the disability prevented the patient from performing **any work, occupation or profession** that the patient can ever sufficiently do or follow to earn or obtain any wages, compensation or profits? ❒ Yes ❒ No

If "No", please advise:

(i) The type of occupation and job duties the patient can perform:

(ii) The limitations faced by the patient:

(iii) The expected date the patient can expect to return to any work, occupation or profession (ddmmyyyy): | | | | | | | | |

If "Yes", please advise:

(i) Is the disability total and permanent? ❒ Yes ❒ No

(ii) Is the disability beyond any hope of recovery? ❒ Yes ❒ No

(iii) To what extent does the patient's disability prevent the patient from performing **any work, occupation or profession**?

(iv) Initial date the patient became unable to perform any work, occupation, or profession (ddmmyyyy): | | | | | | | | |

Please also attach a **detailed report** including all relevant findings and the reasons to support.

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If patient had **no** occupation at time of accident:

20) Based on the **Last consultation mentioned on Section B 1ii) above**, please indicate (by circling as applicable) the patient's ability to perform the Activities of Daily Living (ADLs), **whether aided or unaided** by special equipment, devices, and/or apparatus (and not pertaining to human aid).

Definition of ADL	Extent of Independence	Yes / No	If patient always requires 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 and 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? _____
Dressing: The ability to put on, takes 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? _____

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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 managed 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? _____
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? _____

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21) Did the patient sustain total and permanent loss of an **internal organ**, either through removal or effective Loss of use? ❒ Yes ❒ No

("Loss" refers to complete, irrecoverable, and permanent loss of use, or loss by complete physical Severance.)

If "Yes", please advise:

(i) Was the above caused by the **Accident mentioned in Question 2)**? ❒ Yes ❒ No

(ii) Organ affected:

- ❒ Pancreas
- ❒ Lung
- ❒ Kidney
- ❒ Spleen
- ❒ Liver
- ❒ Heart transplant
- ❒ Others, please specify:

(iii) For **Heart Transplant**, please provide the following:

a) Was the transplant required due to irreversible end-stage heart failure? ❒ Yes ❒ No

b) Was there rupture or tear? ❒ Yes ❒ No

c) Was there an infection arising from infectious diseases? ❒ Yes ❒ No

Please provide details and attach relevant hospital reports to support.

22) Did the patient sustain permanent and total loss, or total loss of use, of any **limb?** ❒ Yes ❒ No

("Loss" refers to complete, irrecoverable, and permanent loss of use, or loss by complete physical Severance.)

If "Yes", please advise:

(i) Was the above caused by the **Accident mentioned in Question 2)**? ❒ Yes ❒ No

(ii) Describe in detail the affected **limb**:

(iii) For loss related to **thumb, finger or toe**, please specify the following:

Which finger or toe	Affected phalanx/phalanges

Please provide details and attach relevant hospital reports to support.

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23) Did the patient suffer from **major burns**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Was the above caused by the **Accident mentioned in question 2)**? ❒ Yes ❒ No

(ii) Is the patient suffering from full-thickness skin destruction? ❒ Yes ❒ No

(iii) Please specify the following:

Area(s) affected on the patient's body	Percentage (%) of surface area	Degree of burns

Please provide details and attach relevant hospital reports to support.

25) Did the patient suffer from **permanent and incurable insanity**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Was the state of mental disability caused by the **Accident mentioned in Question 2)**? ❒ Yes ❒ No

(ii) Is the patient permanently institutionalised in a mental home or equivalent institution? ❒ Yes ❒ No

(iii) Has the patient been permanently institutionalised for at least 12 continuous months? ❒ Yes ❒ No

(iv) Name and address of Psychiatrist who recommended the admission:

(v) Name and address of the mental home or equivalent institution:

(vi) Date of recommendation (ddmmyyyy):

(vii) Date of admission (ddmmyyyy):

(viii) Date of discharge (ddmmyyyy):

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26) (i) Did the patient sustain **total and permanent loss of teeth** caused by the **Accident mentioned in Question 2)**?

❒ Yes ❒ No

If "Yes", please provide details of teeth affected:

Teeth Number	Teeth Names

(ii) Are the affected teeth sound and natural permanent teeth? ❒ Yes ❒ No

If "Yes", please provide details of teeth affected:

Teeth Number	Teeth Names

(iii) Are the affected teeth first or milk teeth? ❒ Yes ❒ No

If "Yes", please provide details of teeth affected:

Teeth Number	Teeth Names

(iv) Are the affected teeth dentures? ❒ Yes ❒ No

If "Yes", please provide details of teeth affected:

Teeth Number	Teeth Names

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(v) Are the affected teeth implants? ❒ Yes ❒ No

If "Yes", please provide details of teeth affected:

Teeth Number	Teeth Names

(vi) Do the affected teeth have dental fillings? ❒ Yes ❒ No

If "Yes", please provide details of teeth affected:

Teeth Number	Teeth Names

Please attach relevant hospital reports and x-ray reports.

27) Did the patient undergo **surgical operation to remove the lower jaw**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Was the above caused by the **Accident mentioned in Question 2)**? ❒ Yes ❒ No

(ii) Date of operation (ddmmyyyy):

Please provide details and attach relevant hospital reports and operation reports to support.

For females only,

28) Did the patient suffer from a **miscarriage**? ❒ Yes ❒ No

If "Yes", please advise:.

(i) Date of miscarriage (ddmmyyyy)

(ii) How many weeks the patient was pregnant prior to the accident?

Please provide details and attach relevant hospital reports and operation reports to support.

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29) Did the patient sustain any **fracture of the bone**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Was the above caused by the **Accident mentioned in Question 2)**? ❒ Yes ❒ No

(ii) Describe in detail the exact location of the fractured bone(s).

(iii) Is the injury an Open or Closed Fracture? ❒ Open Fracture ❒ Closed Fracture
Please tick **(√)** box.

(iv) Specify the number of bone(s) fractured:

Please provide details and attach relevant hospital reports and x-ray reports to support.

30) Did the patient sustain any **dislocation of the bone**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Was the above caused by the **Accident mentioned in Question 2)**? ❒ Yes ❒ No

(ii) Describe in detail the exact location of the dislocated bone(s):

(iii) Was surgery under anaesthesia required to treat the dislocation? ❒ Yes ❒ No

Please provide details and attach relevant hospital reports and x-ray reports to support.

31) Was the patient referred to a physiotherapist for further management? ❒ Yes ❒ No
If "Yes", please provide the name and address of the physiotherapist:

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

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33)	Is the patient's condition directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?		
(i)	The influence of alcohol, voluntarily or involuntarily? If "Yes", please state the blood alcohol concentration level:	❒ Yes	❒ No
(ii)	The influence of drugs or Intoxication, voluntarily or involuntarily? If "Yes", please state name of drugs and quantity of drugs consumed:	❒ Yes	❒ No
(iii)	The taking of poison or inhalation of gas, voluntarily or involuntarily?	❒ Yes	❒ No
(iv)	The use of unprescribed drugs where such drugs are required by law to be prescribed by a registered doctor?	❒ Yes	❒ No
(v)	Bodily infirmity, mental, psychiatric, anxiety, nervous disorders, sleep disturbance disorders?	❒ Yes	❒ No
(vi)	Birth defects, including hereditary conditions or congenital anomalies?	❒ Yes	❒ No
(vii)	Childbirth, pregnancy, and complications thereof?	❒ Yes	❒ No
(viii)	Any form of dental care or surgery?	❒ Yes	❒ No
(ix)	Treatment for obesity, weight management program?	❒ Yes	❒ No
(x)	Treatment for infertility, contraception, sterilisation, impotence, sexual dysfunction or assisted conception tests or sex change operations?	❒ Yes	❒ No
(xi)	Any elective surgery, cosmetic or plastic surgery not necessitated by injury or illness?	❒ Yes	❒ No
(xii)	Any infection other than an infection occurring simultaneously with and in consequence of a cut or wound of an Accidental Injury?	❒ Yes	❒ No
(xiii)	Human Immunodeficiency Virus infection, AIDS, or any sexually transmitted disease?	❒ Yes	❒ No
(xiv)	Self-inflicted injury, while sane or insane?	❒ Yes	❒ No
(xv)	Suicide, attempted suicide, while sane or insane?	❒ Yes	❒ No
(xvi)	Engagement or involvement in hazardous activity (e.g. aerial activity, rock climbing, mountaineering, underwater activities, bungee-jumping, martial arts activities, boxing, etc)?	❒ Yes	❒ No
(xvii)	Engagement or involvement in sports on a professional or competitive basis?	❒ Yes	❒ No
(xviii)	Injuries sustained during travel in or on any type of aircraft?	❒ Yes	❒ No
(xix)	Committing, attempting, or provoking an assault or a felony or any violation of the law?	❒ Yes	❒ No
(xx)	Treatment of an experimental nature?	❒ Yes	❒ No
(xxi)	Treatment of an investigational nature?	❒ Yes	❒ No
(xxii)	Treatment of a research nature?	❒ Yes	❒ No
(xxiii)	Treatment of a preventive nature?	❒ Yes	❒ No
(xxiv)	Treatment of a screening nature?	❒ Yes	❒ No
If any of the conditions listed in Question 33 (i) to (xxiv) above is are answered as "Yes", please provide details:			

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34) 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 applicable: | | | | | | | | |

35) 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) X-Ray
(iv) Operation reports, surgical reports
(v) Referral letters (if any)
(vi) Any other investigation reports

D) 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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