



Disability Income and/or Total & Permanent Disability and/or Terminal Illness Claim - Doctor's Statement

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

A) Patient's Particulars										
Name of Patient	Gender	Occupation								
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)									
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
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):	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
(ii) Date of Last Consultation (ddmmyyyy):	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
(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? <input type="checkbox"/> Yes <input type="checkbox"/> No										
If "Yes", since when? (ddmmyyyy):	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
If "No", please provide name and address of the patient's regular doctor:										
3) Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No										
If "Yes", please advise:										
(i) Date referred (ddmmyyyy):	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
(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? <input type="checkbox"/> Yes <input type="checkbox"/> No										
(i) Date referred (ddmmyyyy):	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									
(ii) Reason for referral:										
(iii) Name and address of doctor referred to:										

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, 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 **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 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 Disability / Illness

1) Please provide details of the disability/illness:

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

--	--	--	--	--	--	--	--	--	--

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

(iii) Date of onset of these symptoms (ddmmyyy):

--	--	--	--	--	--	--	--	--	--

(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):

--	--	--	--	--	--	--	--

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

--	--	--	--	--	--	--	--

2) What were the **physical** disability and limitation(s) presented during the **Last** consultation?

3) What were the **mental** disability and limitation(s) presented during the **Last** consultation?

4) Please state your assessment of the patient's limb power:

Date of Assessment (ddmmyyyy)	Limb Power	Limb Power	Limb Power
	Left upper limb		Right upper limb
	Left lower limb		Right lower limb

5) Please state your assessment of the patient's power grip and precision grip:

Date of Assessment (ddmmyyyy)	Power Grip	Power Grip	Power Grip
	Left upper limb		Right upper limb
	Left lower limb		Right lower limb

Date of Assessment (ddmmyyyy)	Precision Grip	Precision Grip	Precision Grip
	Left upper limb		Right upper limb
	Left lower limb		Right lower limb

6) 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.

7) Name and address of the doctor who **First** diagnosed the patient with this condition.

8) Is the condition a result of a bodily injury caused solely by an **Accident**? Yes No

If **'No'**, please proceed to Question 9.

If **'Yes'**, please advise:

(i) Date of Accident (ddmmyyyy):

--	--	--	--	--	--	--	--

(ii) Time of Accident:

--

a.m. / p.m.

(iii) Place of Accident:

(iv) Describe in detail how the accident happened:

(v) Describe the extent and severity of the bodily injuries/disability sustained, including the exact site(s) of the body affected:

(vi) Was the accident reported to the police? Yes No

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division

Name of Police Officer-in-charge

(vii) Was the patient under the influence of alcohol and/or drug(s) at the time of accident? Yes No

If "Yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test; name of drug(s), quantity consumed, etc.):

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

10) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitation, including the degree of cognitive and/or intellectual impairment.

14) What was the patient's response to the treatment?

15) Has the patient's condition improved, deteriorated, or remained static? (Please circle as applicable)

(i) Since the disability commenced? Improved / Deteriorated / Remained static

(ii) Since the six (6) months prior to the **Last** consultation? Improved / Deteriorated / Remained static

16) If recovery can be reasonably expected, please describe the extent of possible recovery in the next:

(i) Three (3) to six (6) months:

(ii) Six (6) to twelve (12) months:

17) Please advise:

Patient's occupation just before the disability	Patient's nature of job duties just before the disability

18) 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) To what extent does the patient's disability prevent him/her from performing **his/her usual occupation**?

(ii) Date that the patient first became unable to perform all the normal duties of his/her usual occupation (ddmmyyyy):

--	--	--	--	--	--	--	--	--	--

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

19) 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) What type of occupation and job duties can the patient perform?

(ii) What is/are the limitation(s)?

(iii) Date that the patient is expected 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 doing **any work, occupation, or profession**?

(iv) Initial date that the patient cannot perform any work, occupation, or profession (ddmmyyyy):

--	--	--	--	--	--	--	--

Please also attach a **detailed report** giving all findings relevant to the case the reasons to support.

20) Based on the **Last** consultation, is the patient suffering from total and irrecoverable:

i) Loss of the sight of both eyes?

Yes No

If "Yes", when did such disability commence? (ddmmyyyy)

--	--	--	--	--	--	--	--

ii) Loss of sight of one (1) eye and loss by severance or loss of use of one (1) limb or above the ankle or wrist?

Yes No

If "Yes", when did such disability commence? (ddmmyyyy)

--	--	--	--	--	--	--	--

iii) Loss by severance or loss of use of both hands at or above the wrist?

Yes No

If "Yes", when did such disability commence? (ddmmyyyy)

--	--	--	--	--	--	--	--

iv) Loss by severance or loss of use of both feet at or above the ankles?

Yes No

If "Yes", when did such disability commence? (ddmmyyyy)

--	--	--	--	--	--	--	--

v) Loss by severance or loss of use of one (1) hand at or above the wrist and one (1) foot at or above the ankle?

Yes No

If "Yes", when did such disability commence? (ddmmyyyy)

--	--	--	--	--	--	--	--

21) Is the patient confined to a home, hospital or other institution that provides constant care and medical attention?

Yes No

If "Yes", please state the start date of confinement (dmmyyy):

--	--	--	--	--	--	--	--

Name and address where the patient is residing now:

22) 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.

23) 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:

24) Is the patient's diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection?

Yes No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (ddmmyyy):

--	--	--	--	--	--	--	--

Date the patient **First** became aware of the condition (ddmmyyy):

--	--	--	--	--	--	--	--

Name and Address of doctor who **First** diagnosed the patient

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

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

- (i) Self-inflicted injury? Yes No
- (ii) Suicide? Yes No
- (iii) Wilful misuse of alcohol? Yes No
- (iv) Wilful misuse of drugs? Yes No
- (v) Congenital anomaly or defect? Yes No

If "Yes" for any of the above, please advise:

Condition	Name and Address of doctor who First diagnosed the patient	Date of Diagnosis (ddmmyyyy)	Date the patient First became aware of the condition (ddmmyyyy)	Blood Alcohol Concentration Level	Name of Drugs	Quantity of Drugs consumed
Congenital anomaly or defect				Not Applicable		
Wilful misuse of alcohol			Not Applicable		Not Applicable	
Wilful misuse of drugs			Not Applicable			

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

D) Additional Information

1) Based on the **Last consultation mentioned on Section B 1ii) above**, please **circle** as applicable in relation to the patient's ability to perform the Activities of Daily Living (ADLs), **whether aided or unaided** by special equipment, device 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:								
<p>Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.</p>	<ul style="list-style-type: none"> • 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. 	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="954 645 1422 703"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Dressing: The ability to put on, take off, secure, and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.</p>	<ul style="list-style-type: none"> • 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. 	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="954 1155 1422 1214"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.</p>	<ul style="list-style-type: none"> • 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. 	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="954 1706 1422 1765"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								

<p>Mobility: The ability to move indoors from room to room on level surfaces.</p>	<ul style="list-style-type: none"> • 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. 	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="954 434 1417 495"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions to maintain a satisfactory level of personal hygiene.</p>	<ul style="list-style-type: none"> • 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. 	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="954 891 1417 952"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Feeding: The ability to feed oneself once food has been prepared and made available.</p>	<ul style="list-style-type: none"> • 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. 	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="954 1350 1417 1411"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								

2) Please indicate which ADLs the patient requires the physical assistance of another person for **more than 74% of the time** in performing each activity, **even with** the use of **adaptive equipment**.

Please tick	Activities of Daily Living (ADLs)	Please tick	Activities of Daily Living (ADLs)
	Washing/Bathing		Mobility
	Dressing		Toileting
	Transferring		Feeding

Please elaborate how you arrive at the assessment.

3) What tests or assessments were used to evaluate the patient's functional ability for each of the ADLs mentioned above (e.g. standardised functional assessments, observation of patient performing ADL-specific tasks etc.)?

4) If your assessment of the patient's functional ability for any of the ADLs was based on report(s) provided by the patient or their relatives, please attach a copy of the relevant report(s).

5) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient has consulted for the **condition or any other related diseases**? Yes No
 If "Yes", please advise:
Name of doctor and Address of hospital/clinic Date **First & Last** consulted Reasons for consultation

6) Are further investigations planned? Yes No
 If "Yes", please elaborate:
 If "No", please give reason(s):

7) What is your recommendation for the patient's future case management, including any proposed rehabilitation program or surgeries?

8) Is the patient still on follow-up at your hospital/clinic? Yes No
 If "Yes", please state date of next appointment (ddmmyyy):

--	--	--	--	--	--	--	--	--

 If "No", please state date of discharge (ddmmyyy), if any:

--	--	--	--	--	--	--	--	--

9) 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

E) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor

Address & Official Stamp of Doctor

Name of Doctor

Date (ddmmyyy)