



**Critical Illness Claim - Doctor's Statement
Irreversible Loss of Speech / Permanent (or Temporary) Tracheostomy /
Irreversible Loss of Speech due to neurological disease**

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

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|--|---|--|--|--|--|--|--|--|--|
| A) Patient's Particulars | | | | | | | | | |
| Name of Patient | Gender | | | | | | | | |
| NRIC/FIN or Passport No. | Date of Birth (ddmmyyyy) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <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> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| 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%; height: 20px; border-collapse: collapse;"> <tr> <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> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| (ii) Date of Last Consultation (ddmmyyyy) | <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <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> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| (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%; height: 20px; border-collapse: collapse;"> <tr> <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> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| 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 provide: | | | | | | | | | |
| (i) Date referred (ddmmyyyy) | <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <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> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| (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%; height: 20px; border-collapse: collapse;"> <tr> <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> <td style="width:12.5%;"></td> </tr> </table> | | | | | | | | |
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| (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. cyst, 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 habits past and present **smoking** habits, 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 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 Illness

1) Please provide details of the condition:

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

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(ii) Details of symptom(s) presented during the **First** consultation.

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

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(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 (ddmmyyy)

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| (viii) Date the patient First became aware of the illness/condition. (ddmmyyyy) | <table border="1" style="width: 100%; height: 20px;"> <tr> <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> <td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | |
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| 2) Name and address of the doctor who First diagnosed the patient with the condition. | | | | | | | | | |
| 3) 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. | | | | | | | | | |
| 4) Is the loss of speech as a result of injury <i>or</i> disease of the vocal cord? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details: (i) Injury to vocal cord: (ii) Disease of vocal cord: | | | | | | | | | |
| 5) Is the loss of speech contributed by or associated with (i) any neurological related causes? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) any psychiatric related causes? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to the above, please provide details on the date of diagnosis, exact diagnosis and name and address of attending doctor. | | | | | | | | | |
| 6) Is the patient currently undergoing any speech therapy sessions? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please advise: Frequency <input style="width: 150px; height: 20px;" type="text"/> Duration <input style="width: 150px; height: 20px;" type="text"/> If "No", please state date of Last speech therapy session (ddmmyyyy) <input style="width: 150px; height: 20px;" type="text"/> Has there been any improvement in the patient's speech since onset of the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please elaborate. | | | | | | | | | |

7) Name and address of attending doctor where the sessions were done.

8) Is the loss of speech total and irrecoverable/irreversible? Yes No
 If "Yes", please provide details of the investigation performed to confirm the loss is total and irrecoverable/irreversible.
 Please attach a copy of diagnostic test reports (e.g. fiberoptic nasolaryngoscopy, etc.)

9) Will any surgery improve or could reinstate patient's ability to speak? Yes No
 If "Yes", please advise:
 (i) Name of Surgery

(ii) Date of Operation (ddmmyyyy)

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10) Has a Tracheostomy been performed? Yes No
 If "Yes", please advise:
 (i) Date of Operation (ddmmyyyy)

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(ii) Was the Tracheostomy done for treatment of lung disease or airway disease or as a ventilatory support measure following major trauma or burns? Yes No
 If "Yes", please provide details.

(iii) Was the Tracheostomy done for the purpose of saving life? Yes No
 If "Yes", please provide details.

(iv) Was the Tracheostomy tube remained in place and functional for a period of three (3) months? Yes No
 If "Yes", please advise:
 Date of Removal of the Tracheostomy tube (ddmmyyyy)

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11) Has the inability to speak lasted for a continuous period of 12 months?

Yes No

If "Yes", please state the period the patient has been continuously unable to speak.
Months

12) Was the patient admitted to a hospital for treatment of the diagnosis?

Yes No

If "Yes", please advise:

| Name of the hospital | Hospitalisation Period (including Intensive Care Unit (ICU)) | | Hospitalisation Period in Intensive Care Unit (ICU) | |
|----------------------|--|---------------------------|---|-------------------------------|
| | Admission Date (ddmmyyyy) | Discharge Date (ddmmyyyy) | Admission to ICU (ddmmyyyy) | Discharge from ICU (ddmmyyyy) |
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13) Is the patient's diagnosis or surgery directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection?

Yes No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):

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

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(ii) Wilful misuse of alcohol? Yes No

(iii) Wilful misuse of drugs? Yes No

(iv) 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 |
|------------------------------|--|------------------------------|---|-----------------------------------|----------------|----------------------------|
| HIV or AIDS infection | | Not Applicable | | | | |
| 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) 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 this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please advise: <u>Type of Lifestyle / Exact diagnosis</u> <u>Date of diagnosis</u> <u>Name of doctor & Address of hospital/clinic</u> | |
| 3) Is there anything in the patient's family history that may have increased the risk of this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please advise: <u>Relationship with patient</u> <u>Nature of condition</u> <u>Age of onset</u> <u>Source of information</u> | |
| 4) Have active treatment and therapy now been rejected in favour of relief of symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide full details and explain the reason for this course of action. | |
| 5) 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) Twelve (12) months? <input type="checkbox"/> Yes <input type="checkbox"/> 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. | |
| 6) Please describe and elaborate on the nature and severity of the patient's physical disability and limitation(s). | |

7) 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.

8) (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

9) 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

10) Is the patient still on follow-up at your hospital/clinic? Yes No

If "Yes", please state date of next appointment (ddmmyyy)

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

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11) 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) Nasopharyngoscopy reports
- (iv) Operation reports, surgical reports
- (v) Referral letters (if any)
- (vi) Any other investigation reports

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| 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) | |