* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Major Organ / Bone Marrow Transplantation / Other Organ Transplants / Corneal Transplant / Major Organ or Bone Marrow Transplant (on waitlist)

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) 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? ❒ 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 advise:

(i) Date referred (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 referred (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. anaemia, cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, 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 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 any **major organ failure necessitating the organ transplantation**:

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

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

(iii) Date of onset of these symptoms (ddmmyyyy) | | | | | | | | |

(iv) What is/are the underlying cause(s) of the symptoms?

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(v) **Final** Diagnosis of the underlying disease leading to the major organ transplantation:

(vi) ICD-10 Code:

(vii) Date when illness/condition necessitating organ transplant was **First** diagnosed (ddmmyyyy)

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

2) 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.

3) Name and address of the doctor who **First** diagnosed the patient with the illness/condition necessitating the organ transplant.

4) Was the patient a recipient of a human bone marrow transplant? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of the human bone marrow transplant (ddmmyyyy)

(ii) Was the receipt of human bone marrow transplant using haematopoietic stem cells preceded by total bone marrow ablation? ❒ Yes ❒ No

(iii) Was the patient on official organ transplant waiting list for the receipt of a human bone marrow transplant on Ministry of Health Singapore list of hospital? ❒ Yes ❒ No

(iv) Any additional comments/information:

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5) Was the patient a recipient of the major organ transplant? ❒ Yes ❒ No

If "Yes", please provide:

(i) Date of the major organ transplant (ddmmyyyy) | | | | | | | | |

(ii) Was the receipt of major organ transplant of

(a) Heart ❒ Yes ❒ No

(b) Lung ❒ Yes ❒ No

(c) Liver ❒ Yes ❒ No

(d) Kidney ❒ Yes ❒ No

(e) Pancreas ❒ Yes ❒ No

(f) Stem cell ❒ Yes ❒ No

(g) Others ❒ Yes ❒ No

If "Yes" under "Others", please advise the organ.

(iii) Was the patient on official organ transplant waiting list for the receipt of a major organ transplant on Ministry of Health Singapore list of hospital? ❒ Yes ❒ No

(iv) Was the <u>entire organ</u> or <u>part of the organ</u> transplanted? ❒ Entire ❒ Part

(v) Was there irreversible end-stage failure of the relevant organ that resulted in the transplant? ❒ Yes ❒ No

If "Yes", please advise.

Date of the relevant organ reached irreversible end-stage (ddmmyyyy) | | | | | | | | |

(vi) What medical treatment or replacement therapy had the patient been receiving prior to the transplantation (e.g. dialysis, blood transfusions, etc)?

(ix) Date such treatment commences (ddmmyyyy) | | | | | | | | |

(vii) Date the patient was on the waiting list for the operation (ddmmyyyy) | | | | | | | | |

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6) Was the patient a recipient of the Small Bowel transplant? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of the Small Bowel transplant (ddmmyyyy) | | | | | | | | |

(ii) Was there at least one (1) meter of small bowel with its own blood supply transplant via a laparotomy resulting from intestinal failure? ❒ Yes ❒ No

(iii) Was there intestinal failure? ❒ Yes ❒ No

If "Yes", please advise.

Date of the intestinal failure (ddmmyyyy) | | | | | | | | |

7) Was the patient a recipient of the Corneal transplant? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of the Corneal transplant (ddmmyyyy) | | | | | | | | |

(ii) Was there irreversible scarring with resulting reduced visual acuity, which cannot be corrected with other methods? ❒ Yes ❒ No

If "Yes", please provide full details.

8) Was it the **First** graft? ❒ Yes ❒ No

If "No", please give date of the **First** graft (ddmmyyyyy): | | | | | | | | |

9) Name and address of the **surgeon** who performed the transplant and the **hospital** where the surgery was performed.

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D) Other Information

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

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2) 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): | | | | | | | | |

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

(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).

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

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4) Is there anything in the patient's **lifestyle or personal medical history** that may have increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis	Date of diagnosis	Name of doctor and Address of hospital/clinic

5) Is there anything in the patient's **family history** that may have increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please provide:

Relationship with patient	Nature of illness	Date of diagnosis	Source of information

6) Have active treatment and therapy now been rejected in favour of relief of symptoms? ❒ Yes ❒ No
If "Yes", please provide full details and explain the reason for this course of action.

7) 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.

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

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9) 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.

10) (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

11) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **condition or any other possible related diseases**? ❒ Yes ❒ No
If "Yes", please advise:

Name of doctor and Address of hospital/clinic	Date of **First** & **Last** consultation	Reasons for consultation

12) 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 any. | | | | | | | | |

13) 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, hospitaland laboratory reports. Where applicable, please include the following:

(i) Computerised tomography scan (CT scan)
(ii) Magnetic resonance imaging (MRI), other imaging studies
(iii) Operation reports, surgical reports
(iv) Referral letters (if any)
(v) 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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