Living Benefit Claim - Doctor's Statement
Placenta Increta/Percreta

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. tumour, 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 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 (ddmmyyyy) | | | | | | | | |

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

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

(iv) **Final** Diagnosis of the condition:

(v) ICD-10 Code:

(vi) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

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

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2) Please provide full details and results of all **investigation(s)** (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 condition:

4) Was there an abnormal adherent of the placenta to the myometrium? ❒ Yes ❒ No

5) Was there a presence of severe haemorrhage? ❒ Yes ❒ No

6) Did the patient undergo surgical removal of the placenta? ❒ Yes ❒ No

If "Yes", please advise date of operation (ddmmyyyy)

Please provide a copy of the operation report and histological report.

7) Was this pregnancy conceived through any of the following fertility treatments:

(i) Vitro Fertilization (**IVF**) ❒ Yes ❒ No
(ii) Intra-Cytoplasmic Sperm (**ICSI**) ❒ Yes ❒ No
(iii) Intrauterine Insemination (**IUI**) ❒ Yes ❒ No
(iv) Intracervical Insemination (**ICI**) ❒ Yes ❒ No

If none of the above, please specify the fertility treatment that the patient has received:

8) Was the patient carrying 5 or more babies in this pregnancy? ❒ Yes ❒ No
If "No", please state the **number** of babies that the patient has carried in this single pregnancy.

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9) Is the patient's diagnosis 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 provide details:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):								
Date the patient **First** became aware of the condition (ddmmyyyy):								

(ii) Deliberate misuse of alcohol? ❒ Yes ❒ No

(iii) Deliberate misuse of drugs? ❒ Yes ❒ No

(iv) Self-inflicted illness, injury, suicide or attempted suicide? ❒ Yes ❒ No

(v) Use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? ❒ Yes ❒ No

(vi) Pregnancy complications from fertility treatments? ❒ Yes ❒ No

(vii) Elective abortions? ❒ Yes ❒ No

(viii) Complications arising from child delivery in overseas hospitals and hospitalisation occurring overseas? ❒ 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				
Deliberate misuse of alcohol			Not Applicable		Not Applicable	
Deliberate misuse of drugs			Not Applicable			

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

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10) 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. | | | | | | | | |

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) Biopsy Reports
(ii) Computerised tomography scan (CT scan)
(iii) Magnetic resonance imaging (MRI), other imaging studies
(iv) Ultrasound reports
(v) X-Ray
(vi) Operation reports, surgical reports
(vii) Referral letters (if any)
(viii) 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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