* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Special Benefit - Urinary Incontinence requiring Surgical Repair

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 state over what period does the Hospital/Clinic's record extend?

(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 Reasons 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 the patient was referred:

(iii) Name and address of doctor recommending the referral:

If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E.)

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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:

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, 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 in relation to past and present **smoking**, 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 habits in relation to **alcohol consumption**, 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) | | | | | | | | |

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

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

ICD-10 Code (if applicable):

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

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

2) Name and address of the Hepatologist who **First** diagnosed the patient with the diagnosis.

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) Did the diagnosis result in urinary incontinence? ❒ Yes ❒ No
If "Yes", please provide details.

If "No", please provide details.

5) Has the patient undergone surgery to repair the urinary incontinence? ❒ Yes ❒ No
If "yes", please provide details.

(i) Date of Surgery (ddmmyyyy)

(ii) Type of Surgical Repair performed.

(iii) Has the patient

a) placed under management of a Registered Medical Practitioner for at least six (6) months? ❒ Yes ❒ No
If "yes", please provide details.

Date of Commencement of Management (ddmmyyyy)

b) required continuous incontinence medical treatment? ❒ Yes ❒ No

(iv) Is the surgery medically necessary for the sole purpose of correcting the incontinence? ❒ Yes ❒ No

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D) Other Information

1) Is the patient's diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by:

(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", please provide full details including reasons for the result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and Hospital/Clinic who **First** diagnosed the patient with HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

Please provide copy of test result.

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

3) Has the patient ever been hospitalised for the condition or its related symptoms or complications? ❒ Yes ❒ No
If "Yes", please advise:

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital

4) Is there anything in the patient's **lifestyle** or **personal medical history** which would have increased the risk of the condition? ❒ Yes ❒ No
If "Yes", please advise:

Type of Lifestyle / Exact diagnosis	Date of diagnosis	Name of doctor & address of hospital/clinic

5) Is there anything in the patient's **family history** which would have increased the risk of the condition? ❒ Yes ❒ No
If "Yes", please advise:

Relationship with patient	Nature of condition	Age of onset	Source of information

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6) Has active treatment and therapy now been rejected in favour of relief of symptoms? ❒ Yes ❒ No

If "Yes", please provide full details why this view / course of action is taken.

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 limitations.

9) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitations, 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

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11) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **condition or any possible related illness**? ❒ Yes ❒ No

If "Yes", please advise:

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

12) Please provide us with any other additional information that will enable the Company to assess this claim.

13) Please enclose a copy of all investigation reports including specialist reports, hospital reports, laboratory reports and etc that are available.

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

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