* S U P D O C *

Singlife

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

SECTION 2 – 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)

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 provide:

(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)

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, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc.)? ❒ Yes ❒ No

If "Yes", please provide:

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 Disability / Illness

1) Please provide details of current Disability/Illness:

(i) Date of First consultation for this current condition (ddmmyyyy) | | | | | | | | |

(ii) Details of symptom(s) presented during the First consultation, and date these symptoms First started.

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

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of first diagnosis (ddmmyyyy)

(vi) Date the patient first became aware of the illness/condition (ddmmyyyy)

2) Please provide full details and results of all **investigations** (with dates) undertaken for the diagnosis and **attach** a copy of all relevant test reports which confirmed the diagnosis.

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

4) Is the condition a result of an **Accident**? ❒ Yes ❒ No

If 'No", please proceed to Question 5.

If "Yes", please provide details as follows:

(i) Date of Accident (ddmmyyyy)

(ii) Time of Accident

a.m. / p.m.

(iii) Place of Accident

(iv) Describe how the accident happened.

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

(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

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5)	Was the patient under the influence of alcohol and/or drugs at the time of accident ❒ Yes ❒ No If "Yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.)
6)	Was the condition self-inflicted? ❒ Yes ❒ No If "Yes", please provide full details.
7)	Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation.
8)	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.
9)	Please provide in details the **treatment** prescribed with dates, including type of operation performed, rehabilitation programs (e.g. physiotherapy – number of cycles, commencement and termination date), medication, etc.
10)	What are the name of the doctor(s) and hospital/clinic where the patient received and/or is receiving the abovementioned treatment?

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

12) Based on your latest records, has the patient's condition improved, deteriorated or remained stationary: (Please circle as applicable)

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

(ii) Since the six (6) months prior to the last consultation at your hospital/clinic? Improved / Deteriorated / Remained stationary

13) 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:

14) If recovery is not reasonably expected, is the disability total and permanent, and beyond any hope of recovery? ❒ Yes ❒ No

If "Yes", please provide the basis of your evaluation.

15) Is the disability "total and permanent", ***and*** such that there is neither then nor at any time thereafter 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 "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

16) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

17) Is the patient suffering from total and irrecoverable loss of use of both eyes, *or* two limbs, *or* one eye and one limb, excluding hands and feet? ❒ Yes ❒ No

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

18) Is the patient confined to a home, hospital or other institution that provides constant care and medical attention? ❒ Yes ❒ No

If "Yes", since what date? (ddmmyyyy) | | | | | | | | |

Name and address where the patient is resding now:

19) 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.

20) In your opinion, is the condition highly likely to lead to death within the next:
(a) six (6) months? ❒ Yes ❒ No
(b) twelve (12) months? ❒ Yes ❒ No

If "Yes" to (a) and/or (b), please provide details on the basis of your evaluation.

D) Additional Information (if this is a Total & Permanent Disability Claim)

1) Based on your most recent records, 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 <u>always requires</u> another person's help, please state: (a) Reasons, and (b) For how long has he/she been <u>continuously</u> unable to do so?**
Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath and shower) or wash satisfactorily by other means.	• 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	**Yes / No** **Yes / No** **Yes / No**	
Dressing: The ability to put on, takes off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	• 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	**Yes / No** **Yes / No** **Yes / No**	

D) Additional Information (if this is a Total & Permanent Disability Claim) (Continue)			
1) Based on your most recent records, 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 <u>always requires</u> another person's help, please state:** **(a) Reasons, and** **(b) For how long has he/she been <u>continuously</u> unable to do so?**
Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.	• 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	**Yes / No** **Yes / No** **Yes / No**	
Mobility: The ability to move indoors from room to room on level surfaces.	• 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	**Yes / No** **Yes / No** **Yes / No**	
Toileting: The ability to use the lavatory or otherwise managed bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	• 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	**Yes / No** **Yes / No** **Yes / No**	
Feeding: The ability to feed oneself once food has been prepared and made available.	• 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	**Yes / No** **Yes / No** **Yes / No**	

2) What tests did you use to establish the patient's function for each of the ADLs (e.g. standardised functional assessments, observation of patient performaing ADL-specific tasks, etc.)?
3) If your assessment of the patient's function for each of the ADLs was taken from report(s) provided by the patient or relatives, please attach a copy of such report(s).
4) Please provide us with any other additional information that will enable the Company to assess this claim.
5) Please enclose a copy of all reports including specialist/physiotherapist/hospital/police reports, x-rays, CT scans, laboratory test results, inpatient discharge summary etc. that are available.

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)	