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Attending Physician's Statement Major Disease/Critical Illness Spinal Muscular Atrophy

Patient's Name

Attending Physician's Name

Address

This section must be completed by a qualified and registered physician at the expense of the claimant.

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **SPINAL MUSCULAR ATROPHY**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

A. GENERAL INFORMATION

1. Are you the patient's usual medical doctor? Yes No

If yes, over what period do your records extend to?

Start date _____ / _____ / _____ End date _____ / _____ / _____
 dd mm yyyy dd mm yyyy

2. When did the patient first consult you for this condition? _____ / _____ / _____
 dd mm yyyy

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/M /YYYY)

What / Who is the source of this information? _____

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.
- _____
- _____

5. Did the patient consult any other doctors for these symptoms before he/she consulted you? Yes No
If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address

8. Is there evidence of increased spasticity as diagnosed by a consultant neurologist?

Yes No

If yes, please provide full details and name of the consultant neurologist.

9. Is the diagnosis supported by appropriate neuromuscular testing such as Electromyogram (EMG)? Yes No

If yes, please provide full details of the result and attach a copy.

10. What is the prognosis of the patient and treatment plan?

11. Please provide full details of current treatment provided.

12. Did the condition result in permanent inability to perform, without assistance, at least three of the six Activities of Daily Living?

Yes No

Capabilities (What the patient can do)

Limitations (What the patient cannot do)

13. Has surgical procedure been performed? Yes No

If yes, please provide details.

14. Please provide details of all investigations/tests performed and attach copies of results of any investigations performed, e.g. resting ECGs, ultrasound, surgical reports, X-rays, MRI / CT scans, neurological reports and any other imaging studies, laboratory evidence etc., and other relevant hospital reports.

15. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

Name of Doctor	Name of Clinic/Hospital / Address

C. MEDICAL HISTORY

16. Has the patient previously suffered from the condition specified above or any related illness? Yes No

If yes, please provide details.

17. Is there anything in the patient's medical history which would have increased the risk of Spinal Muscular Atrophy?

Yes No

If yes, please give date of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

18. Please give details of the patient's family history which would have increased the risk of having Spinal Muscular Atrophy (including the relationship, nature of illness, date of diagnosis) Please state source of information. _____

19. Does the patient have or ever had any other significant health condition(s)? Yes No

If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

D. ADDITIONAL INFORMATION

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

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

Name of Attending Physician (Please print)

Degree/Specialty

Signature

Date Signed

PRC Number / PTR Number

Telephone Number (s)

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.