



**B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS**

6. (a) What is the diagnosis? Please describe the full and exact diagnosis of the condition causing total and permanent disability.

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(b) Date of diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 dd mm yyyy

(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/ Hospital and Address

(d) Date when patient was first made aware of the diagnosis? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 dd mm yyyy

(e) Date when patient was first made aware that the illness/condition was total and permanent.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 dd mm yyyy

7. Is the condition was a result of an accident?  Yes  No

If yes, please provide the following information.

(a) Date of accident. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(b) Please describe in detail how the accident happened.

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(c) Please describe the injuries suffered by the patient.

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(d) What is the prognosis?

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**C. PATIENT'S CONDITION**

8. (a) Please describe fully the nature and severity of the patient's current disability.

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(b) Is the patient confined to a home, hospital or similar institution that provides constant care and medical attention?

Yes       No

(c) Please comment on the patient's range of movement.

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(d) Does the patient have full power of all limbs?       Yes       No

If no, please state which limb(s) do(es) not have full power and the corresponding muscle power?

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(e) What is the likelihood of improvement in motor function over time?

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(f) Please provide full details with respect to the patient's mental abilities and cognition.

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(g) Please describe the past and current treatment provided, including any operations performed and whether it is likely to improve his/her condition.

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- (h) Is the patient compliant with the recommended treatment program?  Yes  No  
If no, please elaborate.

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- (i) What treatment is planned for the future?

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- (j) How often must the patient be on follow-up for this condition?

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- (k) Please provide all duties of the patient's usual occupation, including percentage of time spent in each.

Duties	Percentage%
<hr/>	<hr/>
<hr/>	<hr/>

- (l) Please provide full details of the patient's capabilities and limitations in relation to his/her usual occupation.

**Capabilities (What the patient can do)**

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**Limitations (What the patient cannot do)**

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- (m) Is the patient able to perform all the normal duties of his/her usual condition?  Yes  No

If yes, when is he/she expected to return to his usual occupation.        /        /         
dd mm yyyy

If no, when did he/she cease all work.

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
dd mm yyyy

(n) If the patient is unable to return to his/her usual occupation, is he/she able to engage in any occupation?

Yes  No

If yes, please provide us with the following details.

(a) What type of occupation can he/she engage in?

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(b) When is he/she expected to engage in these occupations?

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
dd mm yyyy

(c) In your opinion, is the patient **totally and permanently disabled** as a result of bodily injury or disease and is **unable to engage in any occupation** or whatsoever **or perform any work for income or profit** currently or at anytime thereafter.  Yes  No

If yes, when did such commence. \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
dd mm yyyy

(d) Is the disability due to the occurrence of any of the following:

(i) Total and irrecoverable loss of sight of both eyes  Yes  No

(ii) Loss by severance of two limbs at or above the wrist or ankle  Yes  No

(iii) Total and irrecoverable loss of sight of one eye and loss by severance of one limb at or above the wrist or ankle.  Yes  No

If you have ticked any of the above boxes, please provide details.

(e) Did the disability arise due to any of the following:

(i) Any self-inflicted act or attempt at suicide Yes No

(ii) The patient being under the influence of any alcohol/drug Yes

(iii) Any mental or nervous disorder Yes No

If you have ticked any of the above boxes, please provide details.

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(f) Is full recovery expected? Yes  No

If yes, please state the expected recovery date. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

If no, please state the prognosis of the patient's condition. \_\_\_\_\_

#### 4. MEDICAL HISTORY

(a) Did the patient previously suffer from any related illness(es) that caused the present condition?  
 No

If yes, please provide details.

\_\_\_\_\_  
\_\_\_\_\_

(b) Is there a family history of this condition? Yes  No

If yes, please provide information such as relationship to insured, nature of illness, date of diagnosis and source of information.

\_\_\_\_\_  
\_\_\_\_\_

(c) Is there a family history of this condition? Yes  No

If yes, please provide information such as relationship to insured, nature of illness, date of diagnosis and source of information.

\_\_\_\_\_  
\_\_\_\_\_

(d) Did the patient consult other doctors for this illness or its symptoms before he/she consulted you? Yes  No

If yes, please provide the name(s) and addresses(es) of the doctor(s) who he/she consulted.

Name of Doctor	Name and Address of Clinic/Hospital	Consultation Dates

(e) Is the patient suffering or has suffered from any other significant illnesses?  
 No

If yes, please provide the following information to us:

Name of Doctor	Name and Address of Clinic/Hospital	Diagnosis Date and Illness
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(f) Please give any other information, which you feel would be helpful in assessment of the patient's claim.

\_\_\_\_\_

\_\_\_\_\_

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

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

\_\_\_\_\_  
**Signature Over Printed Name of Physician**          **Date Signed**

\_\_\_\_\_  
**Qualification**    **Address**

\_\_\_\_\_  
**PRC Number / PTR Number**          **Telephone Number (s)**

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**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.

10. Has active treatment and therapy now been rejected in favor of relief of symptoms?       Yes                   No

If yes, please provide details why this opinion or course of action is taken?

\_\_\_\_\_

\_\_\_\_\_

11. In your opinion,

(a) How long is the expectancy of the patient? \_\_\_\_\_ Months

Please explain and give supporting medical evidence to substantiate your opinion.

\_\_\_\_\_

\_\_\_\_\_

- (b) Is the patient's condition incurable and beyond any hope of recovery?  Yes  No
- (c) Is the advent of death highly probable within 6 months from date of diagnosis?  Yes  No
- (d) Is the advent of death highly probable within 12 months from date of diagnosis?  Yes  No
- (e) Is the patient currently an in-patient in a hospital, nursing home or hospice?  Yes  No

12. Please provide details of all investigation/test performed and attach copies of results of any investigations performed e.g. resting ECGs, exercise stress tests, surgical reports, X-rays, CT scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

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13. 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 and Address

**C. MEDICAL HISTORY**

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

If yes, please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. \_\_\_\_\_

Date of Consultation	Name of Doctor / Address	Diagnosis

15. Is there anything in the patient's medical history which would have increased the risk of the condition resulting in Terminal Illness?  Yes  No

If yes, please provide details including the dates of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. \_\_\_\_\_



Date of Consultation	Name of Doctor / Address	Diagnosis

16. Please provide details of the patient's family history, which would increased the risk of the condition resulting in Terminal Illness (including the relationship, nature of illness, date of diagnosis).

Please state source of information. \_\_\_\_\_

17. Please provide 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. Please state source of information. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

18. Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. \_\_\_\_\_

19. Does the patient have or ever had any other significant health conditions?  Yes  No

If yes, please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. \_\_\_\_\_

Name of Doctor	Name of Clinic/ Hospital/Address	Date of Consultation/Diagnosis

**D. ADDITIONAL INFORMATION**

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

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\_\_\_\_\_

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

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**Signature Over Printed Name of Physician**

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**Date Signed**

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**Qualification**

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**Address**

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**PRC Number / PTR Number**

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**Telephone Number (s)**

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