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ATTENDING PHYSICIAN'S STATEMENT
MAJOR DISEASE/CRITICAL ILLNESS
TOTAL AND PERMANENT DISABILITY

Name

Policy Number/s

Claim Number

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 **TOTAL AND PERMANENT DISABILITY**. 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 _____ / _____ / _____ (dd / mm / yyyy) End date _____ / _____ / _____ (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/MM/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

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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.

_____

_____

(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.

_____

_____

_____

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

_____

_____

(d) What is the prognosis?

C. PATIENT'S CONDITION

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

(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.

(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?

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

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

(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.

_____

_____

(i) What treatment is planned for the future?

_____

_____

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

_____

_____

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

Duties	Percentage%
_____	_____
_____	_____

(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)

_____

_____

Limitations (What the patient cannot do)

_____

_____

(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

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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?

_____

_____

(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 <u>any</u> 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?
Yes ☐ 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?
Yes ☐ 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.

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)**

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.

_____

_____

_____

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

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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. _____

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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

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D. ADDITIONAL INFORMATION

20. 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.

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Signature Over Printed Name of Physician	Date Signed
Qualification	**Address**
PRC Number / PTR Number	**Telephone Number (s)**

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