

ATTENDING PHYSICIAN'S STATEMENT

PART II (To be completed by doctor at Insured's expense)

Name of Insured:	NRIC No.	Occupation declared to you at first consultation:
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History and Circumstances Leading to Disability

- a. Date of disability first started (DD/MM/YY)

- b. Date when the insured first consulted you for this illness (DD/MM/YY):

- c. The symptoms which the insured first related to you on the first consultation:

- d. According to the insured, the duration he/she had been experiencing these symptoms:

- e. Has the insured previously suffered from the illness or any related condition before? If yes, please give dates of consultations and the resulting diagnosis.

Clinical and Physical Findings on First Consultation

- a. The symptoms or physical impairments of the insured observed by you at the first consultation.

- b. The diagnosis of the insured:

- c. If the insured is suffering from Advanced Dementia (including Alzheimer's Disease), please complete the following questions:
 - i. Is there any evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of insured? Yes No
If yes, please specify:
Remarks: _____
 - ii. Did the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric illness and any drug or alcohol related organic disorder? Yes No
If yes, please specify:
Remarks: _____
- d. The date when the insured was first made aware of the illness (DD/MM/YY):

Current Health of Insured

a. The date when the insured last consulted you (DD/MM/YY):

b. Please state the progress of recovery of the insured:

Recovered Improving Static Retrogressed

c. Current state of mobility:

Ambulating without aid Confined to home Confined to bed
Confined to hospital Confined to wheelchair

Please give name of hospital and the period of hospital confinement, if any.

d. Is the insured able to perform without assistance the following (please tick your answer):

- i. Ability to wash and bathe oneself. Yes No
- ii. Ability to dress/undress oneself. Yes No
- iii. Ability to attend to one's own toilet needs. Yes No
- iv. Ability to feed oneself. Yes No
- v. Ability to move independently in and out of bed or a chair. Yes No
- vi. Ability to move indoors from room to room on level surface. Yes No

e. Please describe the current mental impairment of the insured, if any.

Prognosis and Rehabilitation

a. How do you assess the extent of insured's disability?

Totally disabled Partially disabled Too early to determine

Please give date of next review (DD/MM/YY): _____

b. If insured is not totally disabled, what other jobs is he/she capable of performing?

c. If insured is presently totally disabled, how soon is the insured expected to recover from his/her disability?

- 1-3 mths 3-6 mths
- 6-12 mths >12 mths
- Most unlikely to recover

Remarks: _____

d. Please state any further treatment / rehabilitation plan



Additional Information

If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

Please provide name and address of doctor who referred him/her to you

To be completed by Attending Physician / Specialist

Name Of Doctor: _____

Qualification: _____

Signature: _____

Address/Official Stamp:

Date: _____