

ATTENDING PHYSICIAN'S STATEMENT

Part 1 (To be completed by the Insured)

Policy No.	Plan Type	Claim No.
Name of Insured (as shown in NRIC)		NRIC No.
Address of Insured		
Name of Next-of-Kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC No.
Address of Next-of-Kin		

Authorisation

I agree and authorise:

- a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by NTUC Income; and
 - b) NTUC Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer, or organisation or person.
- A photocopy of this form is valid as an original copy.

Signature/Thumbprint of Insured/Next-of-Kin¹

Date (dd/mm/yyyy)

Part 2 (To be completed by the Doctor)

Name of Insured (as shown in NRIC)	NRIC No.
Height of Insured _____ m	Weight of Insured _____ kg
The above readings were taken on this date (dd/mm/yyyy) ____ / ____ / ____	
1. Are you the Insured's usual doctor? Over what period do your records extend? Start Date (dd/mm/yyyy) ____ / ____ / ____	End Date (dd/mm/yyyy) ____ / ____ / ____ <input type="checkbox"/> Yes <input type="checkbox"/> No
2. What is the diagnosis for the Insured's present illness/injury?	
a) What is the exact date of diagnosis? (dd/mm/yyyy) ____ / ____ / ____	
b) Was the Insured informed of the diagnosis? If "Yes", when was he first informed? (dd/mm/yyyy) ____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details.	<input type="checkbox"/> Yes <input type="checkbox"/> No

¹ Please delete accordingly

3. a) Was the condition caused by an accident? If "Yes", please state: Accident Date (dd/mm/yyyy) _____ / _____ / _____ Accident Time _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b) Describe the accident.			
c) Was the accident reported to the police? If you happen to possess a copy of the police report, please enclose it.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
d) Was the Insured under the influence of alcohol/drugs at the time of accident? If "Yes", please state the blood alcohol content/drug type and quantity consumed.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
e) Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Please provide details of the symptoms presented when you first saw the Insured.			
Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)	
5. Was the Insured referred to you by another doctor? If "Yes", please provide details.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Referring Doctor	Name and Address of Clinic/Hospital	Date Insured consulted referring doctor (dd/mm/yyyy)	Reason(s) for the Referral
6. Did the Insured see any other doctor(s) besides those indicated above? If "Yes", please provide details.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Doctor	Name and Address of Clinic/Hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis Made
7. What were the investigations done to confirm the diagnosis?			
Please also enclose copies of all reports used in the management of the Insured's condition(s), e.g. biopsy reports, cytology and histopathology reports, x-rays, CT and MRI scans, other imaging studies, laboratory reports, surgical reports, rehabilitation and occupational therapy report, and other relevant reports.			

8. a) Please provide details of treatment that has been provided (e.g. surgery, chemotherapy, radiotherapy, physiotherapy etc.).			
Type of Treatment	Date of Treatment (dd/mm/yyyy)	Duration of Treatment	Response to Treatment
b) Are there plans for other forms of treatment? If "Yes", please provide full details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Treatment	Expected Date of Treatment (dd/mm/yyyy)		
9. What is the prognosis of the Insured's condition? <input type="checkbox"/> Improve <input type="checkbox"/> Deteriorate <input type="checkbox"/> Remain unchanged			
a) Please describe the nature and severity of the Insured's condition.			
b) Is full recovery expected? If "Yes", please state approximate date (dd/mm/yyyy) _____ / _____ / _____ If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) _____ / _____ / _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
c) At your last assessment, does the Insured have any deficits pertaining to his general motor functions? If "Yes", please provide details in (i) to (iv). Date of last assessment (dd/mm/yyyy) _____ / _____ / _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Range and strength (please indicate power grading of limbs)			
ii. Gait and balance			
iii. Coordination			
iv. Movement			
d) Are there any neurological deficits pertaining to the Insured's sensory functions, or other aspects like hearing, smell, visual? If "Yes", please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is the Insured able to perform all the 6 Activities of Daily Living (feeding, mobility, transferring, washing/bathing, dressing and toileting/continence) independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No
a) If "No", what are the activities the Insured cannot perform independently? Does the Insured require minimal or maximum assistance in these activities?			

b) Is the Insured confined to a home/hospital/or other institution which provides continuous care and medical attention? If "Yes", please provide name and address of this institution, and period(s) of confinement (dd/mm/yyyy).	<input type="checkbox"/> Yes <input type="checkbox"/> No		
11. What was the Insured's occupation before his disability?			
a) What was the nature of his duties?			
b) Does the Insured's disability prevent him from performing the above listed duties? If "Yes", please state why.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
12. a) Has the Insured returned to his usual occupation?			
b) If "No", would the Insured be able to return to his usual occupation at a later date? <input type="checkbox"/> Not able to determine presently (Go straight to Question 15) <input type="checkbox"/> Yes - Expected date of return to his usual occupation is (dd/mm/yyyy) _____ / _____ / _____ <input type="checkbox"/> No - Not possible to return to usual occupation even at a later date	<input type="checkbox"/> Yes <input type="checkbox"/> No		
13. If the Insured cannot return to his usual occupation even at a later date because of his condition, is there any other suitable occupation(s) that he can consider in the future ? <input type="checkbox"/> Yes Examples of such occupation(s) are: _____ Expected date where his condition allows him to engage in these occupation(s) is: (dd/mm/yyyy) _____ / _____ / _____ <input type="checkbox"/> No The Insured's condition makes it highly unlikely for him to take part in any work, occupation or business for remuneration or profit permanently .			
14. If you have answered "No" to Question 13, please state the date when the Insured is considered not able to take part in any work, occupation or business for remuneration or profit permanently . (dd/mm/yyyy) _____ / _____ / _____			
15. If the extent of the Insured's disability cannot be determined at this moment, when would be an appropriate date to assess it? (dd/mm/yyyy) _____ / _____ / _____			
16. a) Please describe the Insured's mental and cognitive abilities.			
b) Is the Insured mentally incapacitated in accordance to the Mental Incapacity Act?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
c) If "Yes" to Question 16b above, please state the date when the mental incapacity started. (dd/mm/yyyy) _____ / _____ / _____			
17. Is the Insured suffering or has suffered from any other disease or ailment? If "Yes", please provide full details.			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Doctor	Name and Address of Clinic/Hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis Made

18. Is the Insured terminally ill, i.e. death is expected within 12 months?

Yes No

19. Please provide us with any other information that will be helpful in the assessment of this claim.

Signature of Doctor

Date (dd/mm/yyyy)

Name and Qualification (printed)

Address & Official Stamp of Clinic/Hospital