

ATTENDING PHYSICIAN STATEMENT - CHILD ILLNESS RIDER

Part 1 (To be completed by the Policyholder/Insured)

Name of Insured (as shown in NRIC)	Policy No.	NRIC No.
Address of Insured		
Name of Policyholder (as shown in NRIC)	Relationship to Insured	NRIC No.
Residential Address of Policyholder		

Record Of Medical Consultations

a) Please provide details of any other doctors or Specialists whom the Insured had consulted in connection with this illness/injury.

Name and Address of Hospital/Clinic	Date of first consultation

b) Name and address of Insured's regular doctor.

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)

SECTION 1: GENERAL INFORMATION

1. Are you the patient's usual medical doctor? If "Yes", over what period do your records extend to?

2. When did the patient first consult you for this condition?

3. When you first saw the patient, what were the symptoms presented and their duration? Please state the date of onset of symptoms.

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?

6. What is the diagnosis? Please provide full details of the diagnosis, including the date of diagnosis.

7. When did the patient and/or the parent first become aware of the condition?

¹ Please delete accordingly.

SECTION 2: DETAIL OF CHILD ILLNESS (Please complete the appropriate section)**SEVERE ASTHMA**

- a) Was there history of status asthmaticus within the past 2 years? Yes No
- b) Did the patient exhibit significant and continuous reduction in exercise tolerance? Yes No
- c) Was there chest deformities resulting from chronic hyperinflation? Yes No
- d) Was there a need for medically prescribed oxygen therapy at home? Yes No
- e) Was the patient on continuous daily use of oral corticosteroids (for a minimum period of 6 months)? Yes No

LEUKAEMIA

a) Please provide details of any chemotherapy or radiotherapy treatment provided, including the dates and type of treatment provided.

b) Please provide details of all investigations performed.

BONE MARROW TRANSPLANT

a) What is the underlying condition for which the patient requires a bone marrow transplant?

b) Has the patient undergone bone marrow transplant?
If "Yes", please provide date of transplant and name of hospital where the transplant was performed. Yes No

c) If the patient has not undergone bone marrow transplant, has the patient been confirmed as accepted onto the official waiting list of the medical or health authorities in Singapore for a transplant, as a recipient?

If "Yes", please provide date and details where the patient was placed on waiting list. Yes No

INSULIN DEPENDENT DIABETES MELLITUS

- a) Was the presence of severe diabetes mellitus characterised by the following:
- i. Loss plasma insulin levels Yes No
 - ii. Episodic ketoacidosis Yes No

b) Please give details if the patient is insulin dependent and enclose a copy of the blood and urine test results.

c) Was there evidence of decreasing C-peptide? Please provide details.

d) Please give details of all investigations done and treatment prescribed.

RHEUMATIC DISEASE WITH VALVULAR IMPAIRMENT

- a) Was there impairment or damage to one or more heart valves and supported by an echocardiogram? Yes No
- b) Was there evidence of history of rheumatic fever? Yes No

c) Please give details of any Group A Streptococcus infection with supporting evidence.

d) Please provide details of all investigations performed and enclose copies of Echocardiogram and laboratory investigations results.

KAWASAKI DISEASE

a) Was there cardiac involvement manifested by dilation and aneurysm formation in coronary arteries? Yes No
If "Yes", please provide details including the date of onset and duration of coronary artery dilation or aneurysm formation.
Please enclose copies of investigations performed confirming this.

b) Was the condition present for at least 6 months after the initial acute episode? Yes No

HAEMOPHILIA

a) Was the condition mild, moderate or severe?

b) Was the clotting factor VIII less than 1%?

 Yes No

c) Was the clotting factor XI less than 1%?

 Yes No**STILL'S DISEASE**

a) Does the patient exhibit the features of Still's Disease? Please provide details.

b) Does the patient require a knee or hip replacement? If "Yes", please provide details.

 Yes No

c) Please enclose copies of all laboratory test results including blood test results.

MENTAL RETARDATION DUE TO SICKNESS, INJURY AND/OR ACCIDENT

a) Was the condition caused by sickness, injury and/or accident?

 Yes No

b) If the condition was due to injury or accident:

i. Please provide the date of the accident and give details on the circumstances leading to the injury or accident.

ii. Were there any contributory factors leading to the injury or accident? (Eg. Influence of alcohol/drugs, self-inflicted injury etc)

c) If the condition was due to sickness:

i. Please provide the date of onset of sickness.

ii. What were the underlying conditions?

d) Has the condition continued without interruption for a period of at least 6 consecutive months after diagnosis?

 Yes No

e) Was the condition caused by congenital illness or condition?

 Yes No**ACCIDENTAL FRACTURE OF SKULL, SPINE, PELVIS OR FEMUR**

a) Was the patient's condition due to an accident?

 Yes No

b) Did the accident result in fracture of skull, spine, pelvis or femur?

 Yes No

c) Did the fracture require hospitalisation?

 Yes No

d) Was the patient's condition a hairline fracture which does not involve the periosteum or the articular surface?

 Yes No

e) Was the patient's condition due to self-inflicted injuries?

 Yes No

f) Was the patient's condition caused by alcoholism or drug addiction?

 Yes No

g) Please provide details of the accident.

i. Date of accident (dd/mm/yyyy): _____

ii. Time of accident _____

iii. Place of accident _____

iv. Describe the extent of injury and state the anatomical site involved

h) Please enclose copies of the X-ray done.

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

We would appreciate if you could enclose copies of all relevant diagnostic and laboratory test results.

Signature of Doctor

Date (dd/mm/yyyy)

Qualification

Address/Official Stamp