

ATTENDING PHYSICIAN'S STATEMENT BENIGN BRAIN TUMOUR

Part 1 (To be completed by Insured)

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| 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 | | |
| <p>Authorisation I agree and authorise:</p> <p>(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</p> <p>(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.</p> <p>A photocopy of this form is valid as an original copy.</p> | | |
| <hr style="width: 80%; margin: 0 auto;"/> Signature/Thumbprint of Insured/Next-of-Kin* | | <hr style="width: 80%; margin: 0 auto;"/> Date (dd/mm/yyyy) |

Part 2 (To be completed by Doctor)

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| Name of Insured (as shown in NRIC) | NRIC No. |
| A. GENERAL INFORMATION | |
| 1. Are you the Insured's usual doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No Over what period do your records extend? Start Date (dd/mm/yyyy): _____ / _____ / _____ End Date (dd/mm/yyyy): _____ / _____ / _____ | |
| 2. When did the Insured first consult you for this condition? (dd/mm/yyyy): _____ / _____ / _____ | |
| 3. When you first saw the Insured, what were the symptoms presented and their duration? Please state date of onset of symptoms. | |
| Symptoms presented | Duration of symptoms |
| | Date symptoms first occurred (dd/mm/yyyy) |
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| | |
| What/who is the source of this information? | |

* Please delete accordingly

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| 4. Did the Insured consult any other doctors for this illness or its symptoms before he/she consulted you? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide details. | | | |
|---|-------------------------------------|--------------------------------------|----------------|
| Name of doctor | Name and address of clinic/hospital | Date(s) of consultation (dd/mm/yyyy) | Diagnosis made |
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B. DETAILS OF DREAD DISEASE

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| 5. a) What is the diagnosis? Please provide full details of the diagnosis. | |
| 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. | |
| d) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy) : _____ / _____ / _____ | |
| 6. a) Is the Insured's condition life threatening? If "Yes", please provide full details. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Has the tumour caused any damage to the brain? If "Yes", please provide full details. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Has the Insured undergone/decided on any surgical removal of the tumour? If "Yes", please state: i) Type of surgery _____ ii) Date of surgery (dd/mm/yyyy): _____ / _____ / _____ iii) Details of histology _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If the tumour has not been surgically removed, has it caused any neurological deficits? If "Yes", please state: i) What are the neurological deficits? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ii) Are the neurological deficits permanent? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) Is Insured's condition a cyst, a granuloma, vascular malformation in or of the arteries of the brain, or haematomas? If "Yes", please state the type: _____ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) Is the Insured's tumour a tumour of the pituitary gland or spine cord? Please state. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| 7. Please provide full details of all treatment provided/planned for (e.g. surgery, chemotherapy, radiotherapy, etc.), including dates and duration of each treatment. | | |
|--|--------------------------------|-----------------------|
| Type of Treatment | Date of Treatment (dd/mm/yyyy) | Duration of Treatment |
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8. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other reliable imaging techniques, laboratory evidence, surgical reports and other relevant hospital reports.

| 9. Please provide details of all doctors and clinics/hospitals to which the Insured has been referred to or attended for this condition. | | | |
|--|-------------------------------------|--------------------------------------|----------------|
| Name of doctor | Name and address of clinic/hospital | Date(s) of consultation (dd/mm/yyyy) | Diagnosis made |
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C. MEDICAL HISTORY

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| 10. Has the Insured previously suffered from Benign Brain Tumour, its symptoms or any related illness? If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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11. Please give details of the Insured's medical history which would have increased the risk of Benign Brain Tumour (including nature of illness, date of diagnosis and source of information).

12. Please give details of the Insured's family history which would have increased the risk of Benign Brain Tumour (including the relationship, nature of illness, date of diagnosis and source of information).

13. Please give details of the Insured's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

14. Please give details of the Insured's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information.

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| 15. Does the Insured have or ever had any other significant health condition(s)? If "Yes", please provide details. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| Diagnosis | Name of doctor | Date of diagnosis (dd/mm/yyyy) | Duration of condition | Treatment received |
|-----------|----------------|--------------------------------|-----------------------|--------------------|
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D. ADDITIONAL INFORMATION

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

Signature of Doctor

Date (dd/mm/yyyy)

Name and Qualification (printed)

Address & Official Stamp of Clinic/Hospital

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