

ATTENDING PHYSICIAN'S STATEMENT KIDNEY FAILURE

Part 1 (To be completed by the Insured)

Policy No.	Plan Type	Claim No.
Name of Insured (as shown in NRIC)		NRIC No.
Address		
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: (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.</p>		
_____ Signature/Thumbprint of Insured/Next-of-Kin*		_____ Date (dd/mm/yyyy)

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC No.	
A. GENERAL INFORMATION		
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. a) When did the Insured first consult you for this condition? (dd/mm/yyyy) _____ / _____ / _____		
b) What is the underlying cause of kidney disease?		
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)
What/Who is the source of this information?		

* Please delete accordingly.

LI/GH/KIDNEY FAILURE APS/09/2010

4. Did the Insured consult any other doctors for this illness or its symptoms <u>before</u> he/she consulted you? If "Yes", please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of doctor	Name and address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made
5. Please describe Insured's condition resulting in kidney failure and Insured's current kidney condition.			
B. DETAILS OF DREAD DISEASE			
6. 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) _____ / _____ / _____			
7. a) Is there chronic renal failure of both kidneys? If "Yes", since when (dd/mm/yyyy): _____ / _____ / _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Is the renal failure reversible?			<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Has the Insured's renal failure reached end-stage? If "Yes", since when (dd/mm/yyyy): _____ / _____ / _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Does the Insured currently require permanent regular peritoneal dialysis or haemodialysis? If "Yes" please state: i) Type of dialysis: _____ ii) Date of FIRST dialysis (dd/mm/yyyy) _____ / _____ / _____ iii) Number of dialysis per week: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Has kidney transplantation been performed? If "Yes" please state: i) Date of kidney transplantation (dd/mm/yyyy) _____ / _____ / _____ ii) Name and address of doctor who performed the kidney transplantation _____ _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No", i) Is surgery planned?			<input type="checkbox"/> Yes <input type="checkbox"/> No
ii) Is the Insured on the waiting list for kidney transplant?			<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Please provide details of all investigations/test performed and attach copies of all hospital surgical procedures including cystoscopy report, histological, radiological reports (x-rays, pyelograms, etc.) 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

C. MEDICAL HISTORY

10. Has the Insured previously suffered from kidney disease or any related illnesses?
If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information.

Yes No

11. Please give details of the Insured's medical history which would have increased the risk of kidney disease (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 kidney disease (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.

15. Does the Insured have or ever had any other significant health condition(s)?
If "Yes", please provide details.

Yes No

Diagnosis	Name of doctor	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

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