income made different

NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 63 INCOME/6346 2663 · Fax: 6338 1500
Email: csquery@income.com.sg · Website: www.income.com.sg
an NTUC Social Enterprise

Attending Medical Practitioner's Statement

Part 1 (To be completed by the Insured)

Policy number	Plan type	Claim number
Name of Insured (as shown in NRIC)		NRIC number
Address of Insured		
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number
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 Income any information as requested by Income; and
b. 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-kin[1]   Date (dd/mm/yyyy)

[1] Please delete accordingly

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC number

Height of Insured ______ m   Weight of Insured ______ kg

The above readings were taken on this date (dd/mm/yyyy) ____/____/____

1. a. Are you the Insured's usual doctor? ☐ Yes ☐ No

   b. Over what period do your records extend?

   Start date (dd/mm/yyyy) ____/____/____   End date (dd/mm/yyyy) ____/____/____

2. What is the diagnosis for the Insured's present illness/injury?

   a. What is the exact date of diagnosis?

   (dd/mm/yyyy) ____/____/____

   b. Please provide us the name and address of the doctor where the diagnosis was first made.

   c. Was the Insured informed of the diagnosis? If "Yes", when was he first informed? ☐ Yes ☐ No

   (dd/mm/yyyy) ____/____/____

   d. Is the Insured's present illness or condition caused by any other underlying disorders? If "Yes", please give details. ☐ Yes ☐ No

3. a. Was the condition caused by an accident? If "Yes", please state: ☐ Yes ☐ No

Accident date (dd/mm/yyyy) ______ /______ /______ Accident time ____________________

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. ☐ Yes ☐ 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. ☐ Yes ☐ No

e. Is the Insured's condition self-inflicted or as a result of suicide? If "Yes", please provide details. ☐ Yes ☐ 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. ☐ Yes ☐ No

Name of referring doctor	Name & 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. ☐ Yes ☐ No

Name of doctor	Name & 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. Has the Insured been compliant with the treatment suggested? If "No", please provide details. ☐ Yes ☐ No

c. Are there plans for other forms of treatment? If "Yes", please provide full details. ☐ Yes ☐ No

Type of treatment	Expected date of treatment (dd/mm/yyyy)	Expected response to treatment

e. Has the Insured rejected any treatment that would improve his current condition? If "Yes", please provide us the following: ☐ Yes ☐ No

i. Type(s) of treatment that would improve Insured's condition

ii. How would the treatment improve Insured's condition and to what extent?

iii. Why did Insured reject the treatment?

9. What is the prognosis of the Insured's condition? ☐ Improve ☐ Deteriorate ☐ Remain unchanged

a. Please describe the nature and severity of the Insured's condition.

b. Is full recovery expected? ☐ Yes ☐ No

If "Yes", please state approximate date (dd/mm/yyyy) ________ /________ /________

If "No", please state the extent of recovery and approximate date (dd/mm/yyyy) ________ /________ /________

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). ☐ Yes ☐ No

Date of last assessment (dd/mm/yyyy) ______ /______ /______

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. ☐ Yes ☐ 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? ☐ Yes ☐ 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). ☐ Yes ☐ 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. ☐ Yes ☐ No

12. a. Has the Insured returned to his usual occupation? ☐ Yes ☐ No

b. If "No", would the Insured be able to return to his usual occupation at a later date?

☐ Not able to determine presently (Go straight to Question 16)

☐ Yes – Expected date of return to his usual occupation is (dd/mm/yyyy) ______ /______ /______

☐ No – Not possible to return to usual occupation even at a later date

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), including sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.) that he can consider **in the future**?

☐ Yes — Examples of such occupation(s) are: ______________________

Expected date when his condition allows him to engage in these occupation(s) is:

(dd/mm/yyyy) ______ /______ /______

If the Insured is unable to engage in sedentary or simpler or desk bound types of occupation (e.g. data entry job, etc.), please provide us the reason(s).

____

____

☐ No — The Insured is unable to take part in any paid work for the rest of his life.

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 paid work for the rest of his life.

(dd/mm/yyyy) ______ /______ /______

15. Is the insured physically or mentally disabled from ever continuing in any employment (including self-employment)? For avoidance of doubt, the difficulty in finding employment is a separate consideration and should not influence your answers to the questions below. ☐ Yes ☐ No

If "Yes", please provide us with reason(s) for your answer and the date (dd/mm/yyyy) when the Insured is permanently incapacitated.

Reason(s):

____

____

Date: (dd/mm/yyyy) ______ /______ /______

16. 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) ______ /______ /______

17. Please tick (✔) and answer all applicable sections. Where not applicable, please indicate 'N.A.'

a. Total and permanent loss of sight

The loss must be permanent and irreversible, even with the use of visual aids.

☐ Right eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

☐ Left eye

Date of total and permanent loss of sight (dd/mm/yyyy)		Date of last review (dd/mm/yyyy)	
Visual acuity		Visual acuity	
Visual field		Visual field	

Please describe the nature and cause of total and permanent loss of sight.

____

____

b. Severance of limbs/total loss of use of limbs

☐ Severance of upper limbs

	Left upper limb	Date (dd/mm/yyyy)	Right upper limb	Date (dd/mm/yyyy)
Severance at or above wrist	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above elbow	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: ________________)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

____

____

☐ Severance of lower limbs

	Left lower limb	Date (dd/mm/yyyy)	Right lower limb	Date (dd/mm/yyyy)
Severance at or above ankle	☐ Yes ☐ No		☐ Yes ☐ No	
Severance at or above knee	☐ Yes ☐ No		☐ Yes ☐ No	
Others (please specify: ________________)	☐ Yes ☐ No		☐ Yes ☐ No	

Please describe the nature and cause of severance.

____

____

☐ Total loss of use (defined as Total and permanent loss of physical function)

	Date of commencement of loss of use (dd/mm/yyyy)	Please describe the nature and cause of total loss of use
Left upper limb		
Left lower limb		
Right upper limb		
Right lower limb		

Please describe the nature and cause of severance.

____

____

18. a. Please describe the Insured's mental and cognitive abilities.

b. Is the Insured mentally incapacitated in accordance to the Mental Capacity Act? ☐ Yes ☐ No

c. If "Yes" to Question 18b above, please state the date when the mental incapacity started.

(dd/mm/yyyy) ______ /______ /______

19. Is the Insured suffering or has suffered from any other disease or ailment? If "Yes", please provide full details. ☐ Yes ☐ No

Name of doctor	Name and address of clinic/hospital	Date Insured consulted doctor (dd/mm/yyyy)	Diagnosis made

20. Is the Insured terminally ill, i.e. death is expected within 12 months? If "Yes", please provide details on the basis of your evaluation. ☐ Yes ☐ No

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) ______ /______ /______

21. 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 and official stamp of clinic/hospital