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# Attending Medical Practitioner's Statement

## Part 1 (To be completed by 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 21 or deceased) | Relationship to Insured | NRIC number |
| Address of next-of-kin | | |

Declarations and Authorisation

I confirm that

(a) my consent to the Personal Data Use Statement ("PDUS") given in the Medical/Accident/Living/Total & Permanent Disability claim form ("MALTPD Form") will apply to this form;

(b) the consent (where applicable) of the third party for the collection, use and disclosure of their personal data for the purposes stated in the PDUS of the MALTPD Form has been duly obtained;

(c) the representation and warranty made in the PDUS will also apply to this form; and

(d) my authorisation and all the declarations given or made by me in the MALTPD Form are valid and applicable to this form.

Signature/Thumbprint of insured/next-of-kin[1] ______________________ Date (dd/mm/yyyy) ______________________

[1] Please delete accordingly

## Multiple Sclerosis
## Part 2 (To be completed by Doctor)

| Name of Insured (as shown in NRIC) | NRIC number |
|---|---|

**A. General information**

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

1. (b) 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) |
|---|---|---|
| | | |
| | | |

What / who is the source of this information?

## Multiple Sclerosis
## Part 2 (To be completed by Doctor)

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. ☐ Yes ☐ No

| Name of doctor | Name and address of clinic / hospital | Date(s) of consultation (dd/mm/yyyy) | Diagnosis made |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**B. Details of dread disease**

5. (a) What is the exact 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. Please provide details, including dates, of the extent of his/her neurological deficit.

7. Were there multiple neurological deficits occurring over a continuous period of at least 6 months? If "Yes", please give details (including dates of each episode). ☐ Yes ☐ No

8. Is there a well-documented history of exacerbations and remissions of said symptoms or neurological deficits? If "Yes", please give details (including dates of each episode). ☐ Yes ☐ No

9. Are there more than 1 episode of well-defined neurological deficit, with persisting signs of involvement of the optic nerves, brainstem and spinal cord together with impairment of co-ordination and motor and sensory function? If "Yes", please give details (including dates of each episode). ☐ Yes ☐ No

## Multiple Sclerosis
## Part 2 (To be completed by Doctor)

10. Was the neurological damage caused by Systemic Lupus Erythematosus (SLE) or Human Immunodeficiency Virus (HIV)? If "Yes", please provide more details to your answer. ☐ Yes ☐ No

11. Please provide details of all investigations performed. Please comment on whether the diagnosis was supported by MRI/CT scan.

12. Please describe in full details, including examination dates, of the insured's current limitations in relation to his/her physical and mental state.

13. Please provide full details of all treatment provided, including dates and duration of each treatment.

| Type of Treatment | Date of Treatment (dd/mm/yyyy) | Duration of Treatment |
|---|---|---|
| | | |
| | | |
| | | |

14. 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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

15. Please state and attach copies of all neurological reports, MRI/CT scan, laboratory and test results.

### C. Medical History

16. Has the Insured previously suffered from the above illnesses or any other possible related illness, especially any consultations however minor in nature, concerning neurological symptoms or complaints? If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information. ☐ Yes ☐ No

17. Please give details of the Insured's medical and/or family history which would have increased the risk of multiple sclerosis (including nature of illness, relationship of family members, date of diagnosis and source of information).

## Multiple Sclerosis
## Part 2 (To be completed by Doctor)

18. 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**

19. 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