Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Email: csquery@income.com.sg · Website: www.income.com.sg

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

Name of next-of-kin (if insured is below 21 or deceased)	Relationship to insured	NRIC number

Address of next-of-kin

Declaration and Authorisation
1. I confirm that I have agreed to the "Personal data use statement" provided in the Medical/Accident/Living/Total & Permanent Disability claim form.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner 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.

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

Kidney Failure
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. (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?

Kidney Failure
Part 2 (To be completed by Doctor)

4. Did the Insured consult any other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐ No
If "Yes", please provide details.

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? ☐ Yes ☐ No
If "Yes", since when (dd/mm/yyyy): _____ /_____ /_____

(b) Is the renal failure reversible? ☐ Yes ☐ No

(c) Has the Insured's renal failure reached end-stage? ☐ Yes ☐ No
If "Yes", since when (dd/mm/yyyy): _____ /_____ /_____

(d) Does the Insured currently require permanent regular peritoneal dialysis or haemodialysis? ☐ Yes ☐ No
If "Yes" please state:
i. Type of dialysis: _____
ii. Date of FIRST dialysis (dd/mm/yyyy): _____ /_____ /_____
iii. Number of dialysis per week: _____

(e) Has kidney transplantation been performed? ☐ Yes ☐ No
If "Yes" please state:
i. Date of kidney transplantation (dd/mm/yyyy): _____ /_____ /_____
ii. Name and address of doctor who performed the kidney transplantation _____
_____

If "No", ☐ Yes ☐ No
i. Is surgery planned?

ii. Is the Insured on the waiting list for kidney transplant? ☐ Yes ☐ No

Kidney Failure
Part 2 (To be completed by Doctor)

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

B. Medical History

10. Has the Insured previously suffered from kidney disease or any related illnesses? ☐ Yes ☐ No
If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information.

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 type of alcohol, 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)? ☐ Yes ☐ No
If "Yes", please provide details.

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

Kidney Failure
Part 2 (To be completed by Doctor)

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