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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 age 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

Alzheimer's Disease / Severe Dementia
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?

Alzheimer's Disease / Severe Dementia
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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

B. Details of dread disease

5. (a) What is the actual 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): _____ /_____ /_____

(e) What are the types of investigation done which confirmed the above diagnosis? Please enclose all relevant laboratory reports.

(f) Please enclose all relevant questionnaires, cognitive test results, imaging test reports, and any other test reports or hospital reports available.

6. Is there evidence of deterioration of intellectual capacity/cognitive function or abnormal behaviour resulting in significant reduction in mental and social functioning and requiring the continuous supervision of the Insured? ☐ Yes ☐ No
If "Yes", please describe findings.

7. Did deterioration or loss of intellectual capacity/cognitive function or abnormal behaviour arise from Alzheimer's disease or irreversible organic disorders? ☐ Yes ☐ No
If "Yes", please provide details.

8. Did deterioration or loss of intellectual capacity/cognitive function or abnormal behaviour arise from non-organic disease such as neurosis and/or psychiatric illnesses? ☐ Yes ☐ No
If "Yes", please provide details.

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9. Has the Insured previously suffered from any neurosis or any other psychiatric disorder?
If "Yes", please give dates of consultations, the resulting diagnosis and the name and the address of the attending doctor and source of information.

☐ Yes ☐ No

Resulting Diagnosis	Diagnosis Date (dd/mm/yyyy)	Dates of Consultations (dd/mm/yyyy)	Name and address of Doctor who treated Insured

10. Was the illness suffered by Insured caused directly or indirectly by alcohol-related brain damage or drug abuse?
If "Yes", please state the details.

☐ Yes ☐ No

11. Was there any cognitive testing done (e.g. Mini-mental state examination, MMSE)?
If "Yes", please provide details.

☐ Yes ☐ No

12. (a) Was MMSE less than 20 out of 30, or an equivalent of this score using other Alzheimer's tests?
(b) Was MMSE less than 24 out of 30, or an equivalent of this score using other Alzheimer's tests?
If "Yes", please state the details.

☐ Yes ☐ No
☐ Yes ☐ No

13. Were there two (2) neuropsychometric tests performed six months apart with a battery of tests which clearly define the severity of the impairment?

☐ Yes ☐ No

Please state
(a) the dates of the two (2) neuropsychometric tests:

_____ /_____ /_____ (dd/mm/yyyy) and _____ /_____ /_____ (dd/mm/yyyy)

(b) the results of each test (and enclose the tests reports):

14. Please provide date of last assessment: _____ /_____ /_____ (dd/mm/yyyy)

15. Was there permanent clinical loss of the ability to do all the following:
- Remember;
- Reason; and
- Perceive, understand, express and give effect to ideas.

Please describe the permanent clinical loss:

☐ Yes ☐ No

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16. a) Is the Insured placed on disease modifying treatment prescribed by a specialist?	☐ Yes ☐ No
b) Is the Insured under the continuous care of a specialist?	☐ Yes ☐ No
17. Is the Insured mentally incapacitated in accordance to the Mental Capacity Act?	☐ Yes ☐ No

18. Please enclose all relevant questionnaires, cognitive test results, neuropsychometric tests results, imaging test reports, and any other test reports or hospital reports available.

19. 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

20. Has the Insured previously suffered from the above illnesses or any possible related illnesses or condition, however minor in nature, which caused the deterioration or loss of intellectual capacity? If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information.	☐ Yes ☐ No

21. Please give details of the Insured's medical history which would have increased the risk of Alzheimer's Disease/Severe Dementia (including nature of illness, date of diagnosis and source of information).

22. Please give details of the Insured's family history which would have increased the risk of Alzheimer's Disease/Severe Dementia (including nature of illness, date of diagnosis and source of information).

23. 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.

24. 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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25. 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

26. 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