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an NTUC Social Enterprise

Attending Medical Practitioner's Statement

Part 1 (To be completed by Insured)

Name of Insured (as shown in NRIC)		NRIC number
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number

Declaration and Authorisation
1. I confirm that I have agreed to the "Personal Data Collection 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

Heart Valve Surgery/Percutaneous Valve Surgery
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

   (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?

4. Did the Insured consult any other doctors for this illness or its symptoms <u>before</u> 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

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B. Details of dread disease

5. (a) What is 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) Date of onset of heart valve abnormality (dd/mm/yyyy): _____ /_____ /_____

(f) Is the heart valve abnormality a congenital defect or arising from a congenital disease? If "Yes", please provide the diagnosis of the congenital defect that causes the heart valve abnormality.	☐ Yes ☐ No
6. (a) Was the diagnosis supported by cardiac catheterization? If "Yes", please provide full details of results and attach a copy of the test report.	☐ Yes ☐ No
(b) Was the diagnosis supported by echocardiogram? If "Yes", please provide full details of results and attach a copy of the test report.	☐ Yes ☐ No

(c) Please tick the type of surgery performed:

- ☐ Open heart surgery
- ☐ Percutaneous balloon valvuloplasty
- ☐ Percutaneous balloon valvotomy
- ☐ Others _____

(d) Date of surgery (dd/mm/yyyy): _____ /_____ /_____

(e) Was there any deployment of: (i) new valve	☐ Yes ☐ No
(ii) percutaneous device	☐ Yes ☐ No
(iii) prosthesis	☐ Yes ☐ No
(f) Was the surgical procedure medically necessary?	☐ Yes ☐ No

(g) Name of surgeon who performed the surgery.

(h) Name and address of hospital where the surgery was performed.

Heart Valve Surgery/Percutaneous Valve Surgery
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7. 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

8. Please provide details of all investigations/tests performed and attach copies of results of any investigations performed, e.g. coronary angiogram, cardiac catheterisation, echocardiogram, operation reports, resting ECGs, exercise stress tests, cardiac enzyme assays, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence 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 any risk factors or related illnesses, e.g. hypertension, diabetes, angina or other cardiovascular diseases?
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 heart valve abnormality (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 heart valve abnormality (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.

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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)? ☐ 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

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 and official stamp of clinic/hospital