AIA General Berhad 201001040438 (924363-W)

H

ATTENDING PHYSICIAN'S STATEMENT

Total & Permanent Disability Claim

To be completed by the Attending Physician / Surgeon at the Claimant's own expenses

Policy No.	NRIC No.	Age
Name of Assured	Built: Height_____ Weight_____	Sex ☐ Male ☐ Female

(A) History & Diagnosis

1. The date when symptoms first appeared or accident happened	_____ (DD/MM/YYYY)	2. Symptoms and complaints presented a) by the Assured and for how long? b) Symptoms according to your opinion	a) _____ _____ b) _____ _____
3. a) Date of first consultation b) Date when the diagnosis was first given	a) _____ (DD/MM/YYYY) b) _____ (DD/MM/YYYY)	4. Clinical and physical findings during first consultation	_____ _____
5. The date when the diagnosis was informed to Assured	_____ (DD/MM/YYYY)	6. The final diagnosis of the condition and its complications	_____ _____
7. The academic qualification, qualified knowledge and training as declared by the Assured.	_____ _____	8. The Assured's occupation (if more than one, state all) and exact nature of occupational duties before disability.	_____ _____
9. The date when the Assured was first absent from work due to the condition.	_____ (DD/MM/YYYY)	10. Has the assured ever had the same or a similar condition? If "Yes", please state when and give details.	☐ Yes ☐ No _____

11. Details of subsequent consultations and treatment rendered by you.

Dates / Period (MM/DD/YY)	Details of Treatment and Progress	Investigation / Special Procedures

12. Names and addresses of other doctors/hospitals attended for treatment of this condition and any other condition/disorder.

Dates of treatment (MM/DD/YY)	Reason for consultation/treatment	Physician/Hospitals attended	Addresses

13. Other diseases and/or Underlying Conditions and Date of Onset.

a) Hypertension Date of onset : _____ (DD/MM/YYYY) b) Hyperlipidaemia Date of onset : _____ (DD/MM/YYYY)

c) Diabetes Date of onset : _____ (DD/MM/YYYY) d) Hepatitis Date of onset : _____ (DD/MM/YYYY)

e) Others - specify _____ (DD/MM/YYYY)

(B) Current Health of the Assured

1. Progress of recovery.

☐ Recovered ☐ Improving ☐ Static ☐ Retrogressed

Remarks: _____

2. Current state of mobility. Give name of hospital and the period of hospital confinement, if any.

☐ Ambulatory ☐ Home Confined ☐ Bed Confined ☐ Hospital confined

Remarks: _____

3. a) Date of last seen? _____ (DD/MM/YYYY)

b) Please describe the current physical impairment.

_____

c) Any restriction of movement of the limbs?

_____

d) Motor power, reflex, sensation, etc.

_____

4. Can the Assured perform the Activities of Daily Living without the use of mechanical equipment, special devices or other aids and adaptations?

a)	Getting in and out of a chair without requiring physical assistance.	☐ Yes	☐ No
b)	The ability to move from room to room without requiring any physical assistance.	☐ Yes	☐ No
c)	The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.	☐ Yes	☐ No
d)	Putting on and taking off all necessary items of clothing without requiring assistance of another person.	☐ Yes	☐ No
e)	The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.	☐ Yes	☐ No
f)	All tasks of getting food into the body once it has been prepared.	☐ Yes	☐ No

5. General Disability. Please tick (✓) where appropriate.

- ☐ Severe Disability: Bedridden, Incontinent, constant nursing care.
- ☐ Moderately Severe Disability: Unable to walk and do bodily care without help.
- ☐ Moderately Disability: Needs some help but walks without assistance.
- ☐ Slight Disability: Unable to carry out some previous activities but looks after own affairs without assistance.
- ☐ No Disability.

6. With the current health condition of the Assured in mind, what would you rate the present working capacity of the Assured?

- ☐ No limitation of functional capacity, capable of heavy work without restrictions.
- ☐ Capable of medium manual activity.
- ☐ Slight limitation of functional capacity, capable of light work.
- ☐ Moderate limitation of functional capacity, capable of clerical/administrative activity.
- ☐ Severe limitation of functional capacity, incapable of minimum activity.

Remarks: _____

7. Please describe the current mental impairment of the Assured.

_____

8. With the current mental status of the Assured as described above, what would you rate the present ability for interpersonal relations and communication of the Assured?

- ☐ Able to engage in all interpersonal relations and communication (without limitations)
- ☐ Able to engage in most interpersonal relations and communication (slight limitations)
- ☐ Able to engage in only limited interpersonal relations and communication (moderate limitations)
- ☐ Unable to engage in all interpersonal relations and communication (marked limitations)
- ☐ Has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks: _____

(C) Treatment & Prognosis

1. Current medication, dosage, for how long and side effects (if any)	Please elaborate in details.		
2. Can his condition be corrected by sugery?	a) if yes, please state in details.	b) If no, what is the reason?	
3. Has the patient reached maximum medical improvement?	Please elaborate in details.		
4. What is patient's prognosis with appropriate treatment and management for the next 12 month?			

(D) Miscellaneous

If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.

_____

I hereby certify that I have personally examined and treated the Assured for his/her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his/her condition.

_____	_____	_____
Signature of Attending Physician		Qualification
	_____	_____
		Contact No.
	_____	_____
	Name & Address (Official Stamp)	Date (DD/MM/YYYY)