


**AIA PUBLIC
TAKAFUL**
ATTENDING PHYSICIAN'S STATEMENT
Total & Permanent Disability Claim
To be completed by the Attending Physician / Surgeon at the Claimant's own expenses

Certificate No.:		IC No.:		Age:	
Name of Person Covered:		Built: Height _____ Weight _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Part A - History & Diagnosis					
1. The date when symptoms first appeared or accident happened	1. _____ (MM/DD/YYYY)	2. Symptoms and complaints presented a) by the Person Covered and for how long? b) Symptoms according to your opinion	2. a) _____ _____ b) _____ _____		
3. a) Date of first consultation b) Date when the diagnosis was first given	3. a) _____ (MM/DD/YYYY) b) _____ (MM/DD/YYYY)	4. Clinical and physical findings during first consultation	4. _____ _____		
5. The date when the diagnosis was informed to Person Covered.	5. _____ (MM/DD/YYYY)	6. The final diagnosis of the condition and its complications	6. _____ _____		
7. The academic qualification, qualified knowledge and training as declared by the Person Covered.	7. _____	8. The Person Covered's occupation (if more than one, state all) and exact nature of occupational duties before disability.	8. _____		
9. The date when the Person Covered was first absent from work due to the condition.	9. _____ (MM/DD/YYYY)	10. Has the Person Covered ever had the same or a similar condition? If "Yes", please state when and give details.	10. <input type="checkbox"/> Yes <input type="checkbox"/> No _____		
11. Details of subsequent consultations and treatment rendered by you.					
<u>Dates / Period (MM/DD/YY)</u>		<u>Details of Treatment and Progress</u>		<u>Investigation / Special Procedures</u>	

12. Names and addresses of other doctors/hospitals attended for treatment of this condition and any other condition/disorder.					
<u>Dates of treatment (MM/DD/YY)</u>		<u>Reason for consultation/treatment</u>		<u>Physician/Hospitals attended</u>	

13. Other diseases and/or Underlying Conditions and Date of Onset.					
a) Hypertension Date of onset : _____ (MM/DD/YYYY)		b) Hyperlipidaemia Date of onset : _____ (MM/DD/YYYY)			
c) Diabetes Date of onset : _____ (MM/DD/YYYY)		d) Hepatitis Date of onset : _____ (MM/DD/YYYY)			
e) Others - specify _____ (MM/DD/YYYY)					
Part B - Current Health of the Person Covered					
1. Progress of recovery.	1. <input type="checkbox"/> Recovered <input type="checkbox"/> Improving <input type="checkbox"/> Static <input type="checkbox"/> Retrogressed Remarks: _____				
2. Current state of mobility. Give name of hospital and the period of hospital confinement, if any.	2. <input type="checkbox"/> Ambulatory <input type="checkbox"/> Home Confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> Hospital confined Remarks: _____				
3. a) Date of last seen? b) Please describe the current physical impairment. c) Any restriction of movement of the limbs? d) Motor power, reflex, sensation, etc.	3. a) _____ (MM/DD/YYYY) b) _____ _____ c) _____ _____ d) _____ _____				

<p>4. Can the Person Covered perform the Activities of Daily Living without the use of mechanical equipment, special devices or other aids and adaptations?</p>	<p>4. a) Getting in and out of a chair without requiring physical assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) The ability to move from room to room without requiring any physical assistance. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Putting on and taking off all necessary items of clothing without requiring assistance of another person. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f) All tasks of getting food into the body once it has been prepared. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. With the current health condition of the Person Covered in mind, what would you rate the present working capacity of the Person Covered?</p>	<p>5. <input type="checkbox"/> No limitation of functional capacity, capable of heavy work without restrictions.</p> <p><input type="checkbox"/> Capable of medium manual activity.</p> <p><input type="checkbox"/> Slight limitation of functional capacity, capable of light work.</p> <p><input type="checkbox"/> Moderate limitation of functional capacity, capable of clerical/administrative activity.</p> <p><input type="checkbox"/> Severe limitation of functional capacity, incapable of minimum activity.</p> <p>Remarks: _____</p>
<p>6. Please describe the current mental impairment of the Person Covered.</p>	<p>6.</p>
<p>7. With the current mental status of the Person Covered as described above, what would you rate the present ability for interpersonal relations and communication of the Person Covered?</p>	<p>7. <input type="checkbox"/> Able to engage in all interpersonal relations and communication (without limitations)</p> <p><input type="checkbox"/> Able to engage in most interpersonal relations and communication (slight limitations)</p> <p><input type="checkbox"/> Able to engage in only limited interpersonal relations and communication (moderate limitations)</p> <p><input type="checkbox"/> Unable to engage in all interpersonal relations and communication (marked limitations)</p> <p><input type="checkbox"/> Has significant loss of psychological, physiological, personal and social adjustment (severe limitations)</p> <p>Remarks: _____</p>

Part C - Prognosis & Rehabilitation

<p>1. Is the Person Covered now totally disabled?</p>	<p>1. a) In terms of his/her own job. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) In terms of any other jobs. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>2. According to the Person Covered academic qualification, qualified knowledge and training, what duties of the Person Covered job is he/she incapable of performing?</p>	<p>2. <input type="checkbox"/> Capable of performing <u>any</u> kind of work and duties.</p> <p><input type="checkbox"/> Capable of performing <u>his/her own</u> duties and occupation only.</p> <p><input type="checkbox"/> Incapable of performing <u>any</u> kind of work and duties.</p>	
<p>3. Do you expect a fundamental or marked change of this present condition in the future?</p>	<p>3. <input type="checkbox"/> Yes <input type="checkbox"/> No , please specify.</p>	
<p>4. If yes, how long do you expect the Person Covered will take to perform duties?</p>	<p>4. In terms of own job</p> <p><input type="checkbox"/> Within 1 month</p> <p><input type="checkbox"/> 1-3 months</p> <p><input type="checkbox"/> 3-6 months</p> <p><input type="checkbox"/> 6-12 months</p> <p><input type="checkbox"/> > 12 months</p> <p><input type="checkbox"/> Never</p> <p>Remarks: _____</p>	<p>In terms of any other job</p> <p><input type="checkbox"/> Within 1 month</p> <p><input type="checkbox"/> 1-3 months</p> <p><input type="checkbox"/> 3-6 months</p> <p><input type="checkbox"/> 6-12 months</p> <p><input type="checkbox"/> > 12 months</p> <p><input type="checkbox"/> Never</p> <p>Remarks: _____</p>
<p>5. If no, please explain.</p>	<p>5.</p>	
<p>6. Please state any further treatment/ rehabilitation plan.</p>	<p>6.</p>	
<p>7. General Disability. Please tick(✓) where appropriate.</p>	<p>7. <input type="checkbox"/> Severe Disability: Bedridden, Incontinent, constant nursing care.</p> <p><input type="checkbox"/> Moderately Severe Disability: Unable to walk and do bodily care without help.</p> <p><input type="checkbox"/> Moderately Disability: Needs some help but walks without assistance.</p> <p><input type="checkbox"/> Slight Disability: Unable to carry out some previous activities but looks after own affairs without assistance.</p> <p><input type="checkbox"/> No Disability.</p>	

Part 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 Person Covered 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

Name & Address (Official Stamp)

Date: (MM/DD/YYYY)

Contact No.: _____