



**ATTENDING PHYSICIAN'S STATEMENT**

**Critical Illness – Blindness/Total Loss of Sight or Deafness/Total Loss of Hearing or Loss of Speech**

To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age
Name of Assured		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>I) General Information</b>		
<p>1. (a) Are you the Assured's usual medical physician?</p> <p>(b) If "Yes", over what period do your records extend?</p>	<p>1. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) _____ _____</p>	
<p>2. (a) When were you first consulted for this illness?</p> <p>(b) What were the symptoms/complaints?</p> <p>(c) How long had the symptoms/complaints existed :-</p> <p>(i) According to the patient?</p> <p>(ii) In your medical opinion?</p>	<p>2. (a) _____ (DD/MM/YYYY)</p> <p>(b) _____</p> <p>(c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s</p> <p>(ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s</p>	
<p>3. (a) Has the Assured previously suffered from this illness or any related illnesses?</p> <p>(b) If "Yes", please give dates of consultations and the resulting diagnosis.</p> <p>(c) Was the patient referred to you?</p> <p>(i) If Yes, when?</p> <p>(ii) Reasons for referral?</p> <p>(iii) Name and address of the referral doctors.</p>	<p>3. (a) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) _____ _____</p> <p>(c) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(i) _____ (DD/MM/YYYY)</p> <p>(ii) _____</p> <p>(iii) _____</p>	
<p>4. (a) On what date was the diagnosis made?</p> <p>(b) On what date was the Assured first made aware of it?</p>	<p>4. (a) _____ (DD/MM/YYYY)</p> <p>(b) _____ (DD/MM/YYYY)</p>	
<p>5. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.</p>	<p>5. _____ _____</p>	
<p>6. Which of the following factors are present?</p> <p>a) Past history of controlled hypertension</p> <p>b) Past history of uncontrolled hypertension</p> <p>c) Diabetes Mellitus</p> <p>d) Obesity</p> <p>e) Chronic smoker</p> <p>f) Heavy drinker</p> <p>g) Stress</p> <p>h) Hyperlipidaemia</p> <p>i) Others, please specify : _____</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>Date of Onset (DD/MM/YYYY)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

**II) Details of the Assured's Illness**

<p>1. Please provide full and exact details of the diagnosis.</p>	<p>1. _____ _____</p>
<p>2. Please describe the extent of the disease (where applicable).</p> <p>(i) Blindness/Total Loss of Sight</p> <p>(a) When was the date of onset? _____ (DD/MM/YYYY)</p> <p>(b) What is the visual acuity of both eyes at present? _____</p> <p>(c) What forms of treatment were rendered? _____</p> <p>(d) What is the prognosis? _____</p> <p>(e) (i) Will further surgery improve his/her sight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) If "Yes", what kind of surgery will be necessary? _____</p> <p>(ii) Deafness/Total Loss of Hearing</p> <p>(a) Date of Onset. _____ (DD/MM/YYYY)</p> <p>(b) Was the diagnosis confirmed by an audiometric and sound-threshold test? _____</p> <p>(c) Is the Loss of Hearing total and irreversible? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(d) Is the hearing loss of at least eighty (80) decibels in all frequency of hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) Can it be corrected by hearing aid/surgical/other devices? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(iii) Loss of Speech</p> <p>(a) Date of Onset. _____ (DD/MM/YYYY)</p> <p>(b) Duration of the Loss of Speech. _____</p> <p>(c) Is the Loss of Speech considered total and irrecoverable? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2. _____</p> <p>(i) _____ (DD/MM/YYYY)</p> <p>(b) Left _____ Right _____</p> <p>(c) _____</p> <p>(d) _____</p> <p>(e) (i) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) _____</p> <p>(ii) _____ (DD/MM/YYYY)</p> <p>(b) _____</p> <p>(c) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(d) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(e) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(iii) _____ (DD/MM/YYYY)</p> <p>(b) _____</p> <p>(c) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. What was the cause of the Blindness / Total Loss of Sight or Deafness / Total Loss of Hearing or Loss of Speech?</p>	<p>3. _____ _____</p>
<p>4. Was the Assured treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.</p>	<p>4. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____ _____</p>
<p>5. Has the Assured suffered from / been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please provide full details.</p>	<p>5. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____ _____</p>
<p>6. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.</p>	<p>6. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____ _____</p>

**Note:** (i) For Blindness/Total Loss of Sight claims, please enclose copies of all reports including ophthalmologist's reports, visual acuity tests, CT scans and any relevant reports that are available.  
(ii) For Deafness/Total Loss of Hearing claims, please enclose copies of all audiometric and sound-threshold reports, X-rays, CT scans, any other imaging studies, laboratory evidence, angiograms, etc. and any relevant hospital reports that are available.  
(iii) For Loss of Speech claims, please enclose copies of all reports from (Ear, Nose and Throat) specialists, X-rays, laboratory tests, surgical reports and any relevant hospital reports that are available.

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.

<p>Signature of Attending Physician</p>	<p>Qualification</p>
<p>Name &amp; Address (Official Stamp)</p>	<p>Date</p>
<p>Contact No.</p>	<p>(DD/MM/YYYY)</p>