ATTENDING PHYSICIAN'S STATEMENT
Female Product– Down's Syndrome
To be completed by Registered Medical Practitioner at Assured's / Claimant's own expense

Policy No.	NRIC No.	Age
Name of Assured	Sex ☐ Male ☐ Female	

I) General Information

1. (a) Are you the Assured's usual medical physician? (b) If "Yes", over what period do your records extend?	1. (a) ☐ Yes ☐ No (b) _____
2. When were you first consulted for this conditions?	2. _____ (DD/MM/YYYY)
3. Is there an extra chromosome 21?	3. ☐ Yes ☐ No
4. Does the Assured exhibit (a) muscular hypotonicity? (b) microcephaly? (c) branchycephaly? (d) flattened occiput?	4. (a) ☐ Yes ☐ No (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No (d) ☐ Yes ☐ No
5. What is the nature and extent of retardation of physical and mental development?	5. _____
6. Please state if there is anything in the Assured's family history which would have increased the risk of this illness.	6. _____
7. How long has the condition been medically documented?	7. _____

8. Was the Assured treated by any other doctors or hospital? If "Yes", please provide us the dates. ☐ Yes ☐ No

Names of Physicians / Facilities	Addresses	Dates of Consultations / Confinement Periods

9. Please give details of clinical manifestations.

_____

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10. Diagnostics tools, including dates & results (please provide copy of reports).

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11. Present Condition of the Assured.

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12 Prognosis.

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13. Please state if the Assured has previously suffered / been treated for any other illnesses / complaints other than this condition.

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

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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.

_____ Qualification _____

Signature of Attending Physician

Name & Address _____ Date _____

(Official Stamp)

(DD/MM/YYYY)

_____

Contact No. _____