



**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 <input type="checkbox"/> Male <input type="checkbox"/> Female													
<b>(A) History &amp; Diagnosis</b>															
1. The date when symptoms first appeared or accident happened	1. _____ (DD/MM/YYYY)	2. Symptoms and complaints presented a) by the Assured 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) _____ (DD/MM/YYYY) b) _____ (DD/MM/YYYY)	4. Clinical and physical findings during first consultation	4. _____ _____												
5. The date when the diagnosis was informed to Assured	5. _____ (DD/MM/YYYY)	6. The final diagnosis of the condition and its complications	6. _____ _____												
7. The academic qualification, qualified knowledge and training as declared by the Assured.	7. _____	8. The Assured's occupation (if more than one, state all) and exact nature of occupational duties before disability.	8. _____												
9. The date when the Assured was first absent from work due to the condition.	9. _____ (DD/MM/YYYY)	10. Has the assured 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.															
<table style="width:100%; border:none;"> <tr> <td style="width:33%;"><u>Dates / Period (DD/MM/YY)</u></td> <td style="width:33%;"><u>Details of Treatment and Progress</u></td> <td style="width:33%;"><u>Investigation / Special Procedures</u></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>				<u>Dates / Period (DD/MM/YY)</u>	<u>Details of Treatment and Progress</u>	<u>Investigation / Special Procedures</u>	_____	_____	_____	_____	_____	_____			
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_____	_____	_____													
_____	_____	_____													
12. Names and addresses of other doctors/hospitals attended for treatment of this condition and any other condition/disorder.															
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_____	_____	_____	_____												
_____	_____	_____	_____												
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>(B) Current Health of the Assured</b>															
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) _____ (DD/MM/YYYY) b) _____ c) _____ d) _____														

<p>4. Can the Assured 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. General Disability. Please tick(✓) where appropriate.</p>	<p>5. <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>	
<p>6. With the current health condition of the Assured in mind, what would you rate the present working capacity of the Assured?</p>	<p>6. <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>7. Please describe the current mental impairment of the Assured.</p>	<p>7.</p>	
<p>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?</p>	<p>8. <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>	
<p><b>(C) Treatment &amp; Prognosis</b></p>		
<p>1. Current medication, dosage, for how long and side effects (if any)</p>	<p>Please elaborate in details.</p>	
<p>2. Can his condition be corrected by sugery?</p>	<p>a) if yes, please state in details.</p>	<p>b) If no, what is the reason?</p>
<p>3. Has the patient reached maximum medical improvement ?</p>	<p>Please elaborate in details.</p>	
<p>4. What is patient's prognosis with appropriate treatment and management for the next 12 month?</p>		
<p><b>(D) Miscellaneous</b></p>		
<p>If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.</p>		
<p>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>		
<p>_____ Signature of Attending Physician</p>	<p>_____ Qualification</p>	
<p>_____ Name &amp; Address (Official Stamp)</p>	<p>_____ Date: (DD/MM/YYYY)</p>	
<p>Contact No. _____</p>		