AIA PUBLIC TAKAFUL

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

Certificate No:	IC No:	Age:
Name of Person Covered:		Gender: ☐ Male ☐ Female

Part I - General Information

1. (a) Are you the Person Covered'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. _____ (MM/DD/YYYY)
3. Is there an extra chromosome 21?	3. ☐ Yes ☐ No
4. Does the Person Covered 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 Person Covered'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 Person Covered 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.

_____

_____

_____

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

11. Present Condition of the Person Covered.

12 Prognosis.

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

14. 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.: _____