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: ☐ Male ☐ 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. ☐ Yes ☐ No _____

11. Details of subsequent consultations and treatment rendered by you.

Dates / Period (MM/DD/YY)	Details of Treatment and Progress	Investigation / Special Procedures

12. Names and addresses of other doctors/hospitals attended for treatment of this condition and any other condition/disorder.

Dates of treatment (MM/DD/YY)	Reason for consultation/treatment	Physician/Hospitals attended	Addresses

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. ☐ Recovered ☐ Improving ☐ Static ☐ Retrogressed Remarks: _____
2. Current state of mobility. Give name of hospital and the period of hospital confinement, if any.	2. ☐ Ambulatory ☐ Home Confined ☐ Bed Confined ☐ Hospital confined Remarks: _____
3. a) Date of last seen?	3. a) _____ (MM/DD/YYYY)
b) Please describe the current physical impairment.	b) _____ _____
c) Any restriction of movement of the limbs?	c) _____ _____
d) Motor power, reflex, sensation, etc.	d) _____ _____

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

Part C - Prognosis & Rehabilitation

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

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.: _____