income made yours

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Attending Medical Practitioner's Statement

Part 1 (To be completed by Insured)

Policy number	Plan type	Claim number
Name of insured (as shown in NRIC)		NRIC number
Address of Insured		
Name of next-of-kin (if insured is below 21 or deceased)	Relationship to insured	NRIC number
Address of next-of-kin		

Declarations and Authorisation

I confirm that

(a) my consent to the Personal Data Use Statement ("PDUS") given in the Medical/Accident/Living/Total & Permanent Disability claim form ("MALTPD Form") will apply to this form;
(b) the consent (where applicable) of the third party for the collection, use and disclosure of their personal data for the purposes stated in the PDUS of the MALTPD Form has been duly obtained;
(c) the representation and warranty made in the PDUS will also apply to this form; and
(d) my authorisation and all the declarations given or made by me in the MALTPD Form are valid and applicable to this form.

Signature/Thumbprint of insured/next-of-kin[1] Date (dd/mm/yyyy)

[1] Please delete accordingly

Benign Brain Tumour
Part 2 (To be completed by Doctor)

Name of insured (as shown in NRIC)	NRIC number

A. General information

1. (a) Are you the Insured's usual doctor? ☐ Yes ☐ No

1. (b) Over what period do your records extend?

Start Date (dd/mm/yyyy) ______ /______ /______ End Date (dd/mm/yyyy) ______ /______ /______

2. When did the Insured first consult you for this condition? (dd/mm/yyyy): ______ /______ /______

3. When you first saw the Insured, what were the symptoms presented and their duration? Please state date of onset of symptoms.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

What / who is the source of this information?

Benign Brain Tumour
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4. Did the Insured consult any other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐ No
If "Yes", please provide details.

Name of doctor	Name and address of clinic / hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

B. Details of dread disease

5. (a) What is the diagnosis? Please provide full details of the diagnosis.

(b) Date of diagnosis (dd/mm/yyyy): ________ /________ /________

(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

(d) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy): ________ /________ /________

6. (a) Has the tumour caused any damage to the brain? ☐ Yes ☐ No
If "Yes", please provide full details, and enclose supporting diagnostic report(s), such as Magnetic Resonance imaging report, Computerised Tomography report, or report of other reliable imaging techniques.

(b) Has the Insured undergone any surgical removal of the tumour? ☐ Yes ☐ No
If "Yes" please state:

i. Type of surgery ____________________

ii. Date of surgery (dd/mm/yyyy): ________ /________ /________

iii. Details of histology ____________________

iv. Please also enclose a copy of the operation report.

(c) If the tumour has not been surgically removed, is the tumour inoperable? ☐ Yes ☐ No

If "Yes", please state the reason: ____________________

i) What are the neurological deficits?

ii) Are the neurological deficits permanent? ☐ Yes ☐ No
If "Yes", please provide full details.

(d) Is Insured's condition a cyst, abscess, angioma, granuloma, vascular malformation in or of the arteries of the brain, or haematomas? ☐ Yes ☐ No

If "Yes", please state the type: ____________________

(e) Is the Insured's tumour a tumour of the pituitary gland or spine cord or skull base? Please state. ☐ Yes ☐ No

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Part 2 (To be completed by Doctor)

7. Please provide full details of all treatment provided/planned for (e.g. surgery, chemotherapy, radiotherapy, etc.), including dates and duration of each treatment.

Type of Treatment	Date of Treatment (dd/mm/yyyy)	Duration of Treatment

8. Please provide details of all investigations performed and enclose copies of all reports, e.g. biopsy reports, cytology and histopathology reports, X-rays, CT and MRI scans, other reliable imaging techniques, laboratory evidence, surgical reports and other relevant hospital reports.

9. Please provide details of all doctors and clinics/hospitals to which the Insured has been referred to or attended for this condition.

Name of doctor	Name and Address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

C. Medical History

10. Has the Insured previously suffered from Benign Brain Tumour, its symptoms or any related illness? ☐ Yes ☐ No
If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information.

11. Please give details of the Insured's medical history which would have increased the risk of Benign Brain Tumour (including nature of illness, date of diagnosis and source of information).

12. Please give details of the Insured's family history which would have increased the risk of Benign Brain Tumour (including the relationship, nature of illness, date of diagnosis and source of information).

13. Please give details of the Insured's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

14. Please give details of the Insured's habits in relation to alcohol consumption, including the type of alcohol, amount of alcohol consumption per day and source of this information.

15. Does the Insured have or ever had any other significant health condition(s)? ☐ Yes ☐ No
If "Yes", please provide details.

Diagnosis	Name of doctor	Name and address of clinic/ hospital	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

Benign Brain Tumour
Part 2 (To be completed by Doctor)

D. Additional Information

16. Please provide us with any other additional information that will enable us to assess this claim.

Signature of doctor	Date (dd/mm/yyyy)
Name and qualification (printed)	Address & official stamp of clinic/hospital