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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		
Name of next-of-Kin (if insured is below 21 or deceased)	Relationship to insured	NRIC number
Address of next-of-kin		

Declaration and Authorisation
1. I confirm that I have agreed to the "Personal data use statement" provided in the Medical/Accident/Living/Total & Permanent Disability claim form.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner to release to Income any information as requested by Income; and
   (b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner.

A photocopy of this form is valid as an original copy.

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

[1] Please delete accordingly

Stroke / Brain Aneurysm Surgery / Cerebral Shunt Insertion / Carotid Artery Surgery
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

   (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?

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

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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. Please describe the initial episode.

(a) Nature of episode

(b) Date of initial episode (dd/mm/yyyy) _____ /_____ /_____

7. (a) Was there any neurological deficit lasting for at least 6 weeks after the initial episode of Stroke? ☐ Yes ☐ No
If "Yes", please describe the neurological deficit.

(b) What is the prognosis of the Insured's condition? ☐ Improve ☐ Deteriorate ☐ Remain unchanged

(c) Date of Insured's last review (dd/mm/yyyy) _____ /_____ /_____

At the last review, please confirm the following (please tick one):

☐ his neurological deficit is permanent (lasting throughout the lifetime).
If his neurological deficit is permanent,

i. Please describe and elaborate on the nature and severity of the Insured's physical and mental disability and limitations.

ii. What are the activities that Insured still has difficulties with?

☐ he no longer has neurological deficits.
If he has fully recovered, please state the date he returned to normal activities (dd/mm/yyyy) _____ /_____ /_____

☐ unable to determine his neurological status.
When would be an appropriate date to assess this? (dd/mm/yyyy) _____ /_____ /_____

8. Has there been an infarction of brain tissue haemorrhage, embolism and thrombosis from an extracranial source? ☐ Yes ☐ No
If "Yes", please provide full details.

9. Please provide details of all investigations/tests performed and enclose copies of all reports, e.g. CT scan and MRI scan reports, magnetic resonance angiograph (MRA) or angiogram or other imaging studies, laboratory evidence, and other relevant hospital reports.

10. Are the investigation findings consistent with the diagnosis of a new Stroke? ☐ Yes ☐ No
If "Yes", please provide details.

11. Please provide details of treatment that has been provided (e.g. surgery and/or other types of treatment, etc.)

Type of treatment	Date of treatment (dd/mm/yyyy)	Duration of treatment	Response to treatment

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12. (a) Is the condition considered a Transient Ischaemic Attack? ☐ Yes ☐ No
If "Yes", please provide details.

(b) Is the condition a brain damage due to an accident or injury, infection, vasculitis or inflammatory disease? ☐ Yes ☐ No
If "Yes", please provide details.

(c) Is the condition considered a vascular disease affecting the eye or optic nerve? ☐ Yes ☐ No
If "Yes", please provide details.

(d) Is the condition considered an ischaemic disorder of the vestibular system? ☐ Yes ☐ No
If "Yes", please provide details.

13. Has the Insured undergone any Brain Aneurysm Surgery? ☐ Yes ☐ No
If "No", please proceed to Q14

(a) If "Yes", please tick the type of surgery performed.
- ☐ Surgical repair of an intracranial aneurysm
- ☐ Surgical removal of an arterio-venous malformation via craniotomy
- ☐ Others, please state _____

(b) What diagnostic tests were done to confirm the diagnosis? Please enclose a copy of the results.

Name of diagnostic test	Date of diagnostic test (dd/mm/yyyy)	Results

(c) Date Insured was first advised to undergo surgery (dd/mm/yyyy) _____ /_____ /_____

(d) Date of actual surgery (dd/mm/yyyy) _____ /_____ /_____

(e) Was the surgery medically necessary? Please explain. ☐ Yes ☐ No

14. Has the Insured undergone any Cerebral Shunt Insertion from ventricles of the brain to relieve raised pressure in the cerebrospinal fluid? ☐ Yes ☐ No
If "No" please proceed to Q15.

If "Yes",
(a) Please advise the underlying cause of raised pressure in the cerebrospinal fluid and enclose the relevant diagnostic test results available.

(b) Date Insured was first advised to undergo surgery (dd/mm/yyyy) _____ /_____ /_____

(c) Date of surgical implantation of a shunt (dd/mm/yyyy) _____ /_____ /_____

(d) Was the surgery medically necessary? Please explain. ☐ Yes ☐ No

(e) Is there other mode of treatment other than shunt insertion, which could have been used to treat the Insured's raised pressure in the cerebrospinal fluid? ☐ Yes ☐ No
If "Yes", please state the nature of treatment and why this treatment mode was not used.

15. Did the Insured suffer from narrowing of the common Carotid Artery? ☐ Yes ☐ No
If "No", please proceed to Section C.
If "Yes", please advise:

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Part 2 (To be completed by Doctor)

(a) Was an arteriography carried out? If "Yes", please provide a copy of report. If "No", please state how the diagnosis was confirmed and enclose the relevant diagnostic test results available.	☐ Yes ☐ No
(b) Please state the percentage of narrowing of the carotid artery. _____ %	
(c) Was Endarterectomy carried out to correct the narrowing of the carotid artery? If "No", please state the type of treatment provided. If "Yes", please advise:	☐ Yes ☐ No
i. Date Insured was first advised to undergo surgery (dd/mm/yyyy) _____ /_____ /_____	
ii. Date of surgery (dd/mm/yyyy) _____ /_____ /_____	

C. Other information

16. Is the patient's condition or surgery performed in any way related or due to:

(a) AIDS or HIV related illness?	☐ Yes ☐ No
(b) Use of drug not prescribed by a registered medical practitioner or drug abuse?	☐ Yes ☐ No
(c) Alcohol abuse / misuse?	☐ Yes ☐ No
(d) Congenital or inherited disorder?	☐ Yes ☐ No
(e) Attempted suicide or self-inflicted injuries?	☐ Yes ☐ No

If "Yes" for (a) to (e), please provide details below and enclose a copy of the test result.

i. Date of diagnosis (dd/mm/yyyy) _____ /_____ /_____

ii. Exact diagnosis

iii. Name and address of doctor who first diagnosed the patient with the condition

17. 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

D. Additional information

18. Is there anything in the Insured's medical history which would have increased the risk of Stroke, intracranial aneurysm, arterio-venous malformation, hydrocephalus, or narrowing of carotid artery or any related illness (e.g. hypertension, transient ischaemic attack, angina, other cardiovascular diseases, congenital anomaly or defect, etc.)?
If "Yes", please provide details below. ☐ Yes ☐ No

Exact diagnosis	Date of diagnosis	Name of doctor	Name and address of clinic/hospital

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19. Please give details of the Insured's family history which would have increased the risks of having a Stroke (including the relationship, nature of illness, date of diagnosis and source of information.)

20. 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.

21. 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.

22. 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

23. Is the Insured still on follow-up at your clinic? ☐ Yes ☐ No

If "Yes", please provide state date of next appointment (dd/mm/yyyy) _____ /_____ /_____

If 'No", please provide date of discharge (dd/mm/yyyy) _____ /_____ /_____

24. Is the Insured terminally ill, i.e. death is expected within 12 months? ☐ Yes ☐ No
If "Yes", please provide details on the basis of your evaluation.

Please indicate the date on which the Insured is assessed to be terminally ill.

(dd/mm/yyyy) _____ /_____ /_____

25. 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