* S U P D O C *

Singlife

Living Benefit Claim - Doctor's Statement
Congenital Illnesses Benefit – Development Dysplasia of the Hip

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

A) Patient's Particulars

Name of Patient	Gender

NRIC/FIN or Passport No.

Date of Birth (ddmmyyyy) | | | | | | | | |

B) Patient's Medical Records

1) Please state over what period does the Hospital/Clinic's record extend?

(i) Date of **First** consultation (ddmmyyyy) | | | | | | | | |

(ii) Date of **Last** consultation (ddmmyyyy) | | | | | | | | |

(iii) Number of consultations during the above period:

(iv) Name of hospital/clinic and Reasons for consultations (with dates):

2) Are you the patient's usual medical doctor? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy) | | | | | | | | |

If "No", please provide name and address of the patient's regular doctor.

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please provide:

(i) Date referred (ddmmyyyy) | | | | | | | | |

(ii) Reason the patient was referred:

(iii) Name and address of doctor recommending the referral:

If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E.)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy) | | | | | | | | |

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

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5) Does the patient have or ever have had any significant health conditions, medical history, any illness or any congenital condition? If "Yes", please provide: ❒ Yes ❒ No

Details of symptoms	Exact diagnosis	Date diagnosed	Treatment

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

C) Details of Illness

1) Please provide details of **Development Dysplasia of the Hip** condition.

(i) Date the patient **First** consulted you for this condition (ddmmyyyy) | | | | | | | | |

(ii) Details of symptom(s) presented at **First** consultation.

(iii) Date of onset of these symptoms (ddmmyyyy) | | | | | | | | |

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

(vi) Date the patient **First** became aware of this condition (ddmmyyyy) | | | | | | | | |

2) Was the patient born with

(i) Dislocation of hip ❒ Yes ❒ No

(ii) Instability of hip ❒ Yes ❒ No

3) May patient's dislocation of hip or instability of hip result in hip dysplasia? ❒ Yes ❒ No

4) Please confirm if there is evidence suggestive of abnormal development of one or more components of the hip joint that the head of the femur is easily manipulated out of the hip socket. ❒ Yes ❒ No

Please provide copy of report to support the evidence.

5) Had the patient underdone surgery to correct the abnormality? ❒ Yes ❒ No

If "Yes", please provide the details of the surgery:

(i) Date of surgery performed (dd/mm/yyyy) | | | | | | | | |

(ii) Type of surgery performed.

Please provide copy of the surgical report.

If "No" surgery has been performed, please state the treatment provided.

6) What is the underlying cause(s) of the condition?

7) Was this pregnancy conceived through any of the following fertility treatments:

(a) Vitro Fertilization (**IVF**) ❒ Yes ❒ No

(b) Intra-Cytoplasmic Sperm Injection (**ICSI**) ❒ Yes ❒ No

(c) Intrauterine Insemination (**IUI**) ❒ Yes ❒ No

(d) Intracervical Insemination (**ICI**) ❒ Yes ❒ No

If none of the above, please specify the fertility treatment that the patient has received:

8) Was the patient's mother carrying 5 or more babies in this pregnancy? ❒ Yes ❒ No

If "No", please state the **number** of babies that the patient has carried in this single pregnancy.

9) Is the diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by any complications resulting from fertility treatments? ❒ Yes ❒ No

If "Yes", please specify the fertility treatment that the patient has received:

10) Is the patient's diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by:

Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please provide details:

Date of Diagnosis of AIDS/HIV (ddmmyyyy): | | | | | | | | |

Date the patient **First** became aware of the condition (ddmmyyyy): | | | | | | | | |

If "Yes", please provide the details including name of doctor and clinic who first diagnosed the patient with HIV or AIDS, Please provide copy of test result.

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11)	Is the diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by:		
	a) self-inflicted illness, injury?	❒ Yes	❒ No
	b) suicide?	❒ Yes	❒ No
	c) attempted suicide?	❒ Yes	❒ No
12)	Is the diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by deliberate misuse of		
	a) drugs?	❒ Yes	❒ No
	b) alcohol?	❒ Yes	❒ No
13)	Is the diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by drugs where such use of unprescribed drugs are required by the law to be prescribed by a registered medical doctor?	❒ Yes	❒ No
14)	Please provide us with any other additional information that will enable the Company to assess this claim.		
15)	Please provide all investigation results including specialist or hospital reports, laboratory evidence, surgical report, x-ray, CT, MRI or other reliable imaging test investigated for hip dislocation, surgical report, operation report to correct hip dislocation and referral letter (if any).		

D) Declaration	
I hereby declare that the above answers are true to the best of my knowledge and belief.	
Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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