* S U P D O C *

Singlife

Living Benefit Claim - Doctor's Statement
Hospital Care Benefits for Child

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/BC/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 **tick (√)** the box the condition to which this doctor's report relates:

- ❒ Admission into neonatal intensive care unit (NICU) or high dependency unit (HDU)
- ❒ Hospitalisation due to Hand, Foot and Mouth Disease
- ❒ Incubation of the newborn child for more than 3 consecutive days immediately following birth
- ❒ Phototherapy or Blood Transfusion for severe neonatal jaundice
- ❒ Premature birth requiring neo-natal ICU/HDU

2) Please provide details of the 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) | | | | | | | | |

3) Was the patient born prematurely? If "Yes", please provide the details. ❒ Yes ❒ No

(i) Gestation period _____ weeks (ii) Birth weight _____ grams

4) Was the patient incubated for more than 3 consecutive days immediately following birth? ❒ Yes ❒ No

If "Yes", please state the period of incubation (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

5) Was the patient admitted to a Neonatal Intensive Care Unit (NICU)? ❒ Yes ❒ No

If "Yes", please state the period of confinement (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

6) Was the patient admitted to a High Dependency Unit (HDU)? ❒ Yes ❒ No

If "Yes", please state the period of confinement (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

7) Was the patient admitted to a Special Care Nursery (SCN)? ❒ Yes ❒ No

If "Yes", please state the period of confinement (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

Was the Special Care Nursery (SCN) classified as

a) Neonatal Intensive Care Unit (NICU) in your hospital? ❒ Yes ❒ No

b) High Dependency Unit (HDU) in your hospital? ❒ Yes ❒ No

If "Yes", please provide the reason of admitting the patient to the SCN, instead of NICU or HDU.

8) Did the patient requires hospitalisation for at least 3 consecutive days for treatment with

a) Phototherapy within 30 days after birth? ❒ Yes ❒ No

b) Blood transfusion within 30 days after birth? ❒ Yes ❒ No

If "Yes" to any of the above, please confirm the followings:

(i) Was there presence of neonatal jaundice? ❒ Yes ❒ No

If "Yes", please state the **total serum bilirubin level below:**

a. For **term infant, at or greater than 37 weeks gestational age**:

(a) 25 to 72 hours after birth: [ ] µ mol/L (micromol/litre)

(b) More than 72 hours after birth: [ ] µ mol/L (micromol/litre)

(c) Please provide copy of diagnostic and blood test results.

b. For **pre-matured infants, at less than 37 weeks gestational age**:

(a) 25 to 72 hours after birth: [ ] µ mol/L (micromol/litre)

(b) More than 72 hours after birth: [ ] µ mol/L (micromol/litre)

(c) Please provide copy of diagnostic and blood test results.

9) Was the patient hospitalised for **Hand, Foot and Mouth (HFM) disease**? ❒ Yes ❒ No

If "No", please proceed to **question 10**.

If "Yes", please state:

(i) Date of admission (ddmmyyyy): | | | | | | | | |

(ii) **Provisional diagnosis** on admission:

(ii) Were there any viral studies done to confirm the diagnosis of HFM Disease? ❒ Yes ❒ No
If "Yes", please indicate the investigations carried out and their results.

(iii) Did the patient suffer from:

(a) encephalitis during this admission? ❒ Yes ❒ No

(b) myocarditis during this admission? ❒ Yes ❒ No

If "Yes", please provide documented evidence of the presence of the encephalitis or myocarditis.

(iv) Was positive isolation of the causative virus carried out during this admission? ❒ Yes ❒ No

(v) Was the following diagnosed during the admission?

(a) Coxsackie A17 ❒ Yes ❒ No

(b) Enterovirus 71 ❒ Yes ❒ No

(vi) Did the patient suffer any neurological deficit after the date of diagnosis of the HFM Disease? ❒ Yes ❒ No
If "Yes", please state:
(a) Neurological deficits suffered.

(b) Was there evidence of neurological deficit that lasted at least 30 days after the date of diagnosis of the HFM Disease was established? ❒ Yes ❒ No

If "Yes", please elaborate.

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

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

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

(b) Intra-Cytoplasmic Sperm (**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:

12) 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.

13) 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

14) Is the 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)? ❒ Yes ❒ No

If "Yes", please state:

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.

15) 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

16) 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

17) Is the diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by use of unprescribed drugs where such drugs are required by the law to be prescribed by a registered medical doctor? ❒ Yes ❒ No

18) Please provide us with any other additional information that will enable the Company to assess this claim.

19) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.

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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