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an NTUC Social Enterprise

Attending Medical Practitioner's Statement
Benign Brain Tumour

Part 1 (to be completed by the 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

Authorisation
I agree and authorise:
(a) Any medical institution or medical practitioner, or insurer, or organisation or person 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, or insurer or organisation or person.
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

Part 2 (to be completed by the 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?

Part 2 (to be completed by the doctor) (continued)

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) Is the Insured's condition life threatening? ☐ Yes ☐ No
If "Yes", please provide full details.

(b) Has the tumour caused any damage to the brain? ☐ Yes ☐ No
If "Yes", please provide full details.

(c) Has the Insured undergone/decided on 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 _____

_____

If the tumour has not been surgically removed, has it caused any neurological deficits? ☐ Yes ☐ No
If "Yes", please state:

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, a 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? Please state. ☐ Yes ☐ No

Part 2 (to be completed by the doctor) (continued)

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

Part 2 (to be completed by the doctor) (continued)

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