Life Insurance

PERMANENT PARTIAL DISMEMBERMENT - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Life Assured for the injuries / illness sustained.
2. Expenses incurred to obtain this report will be borne by the Life Assured.

Policy No: ……..

1. Name of Patient: ……..
2. NRIC No. : ……..... BC / Old IC No. : …….. Age: ……..
3. Occupation as indicated to you :……
4. Date of **first** consultation with you: ……..... (dd/mm/yyyy) Time ..... (am/pm)
5. Diagnosis: ……..
6. Date of diagnosis ..... (dd/mm/yyyy)
7. What was the underlying cause and pathology of the above diagnosis?

   ……
8. If the cause was due to accident, please state
   i. Date of Accident : ……. (dd/mm/yyyy) Time..... (am/pm)
   ii. Describe in detail the nature of accident as related to you by the patient:

   .....…….....
   iii. Was the patient under the influence of intoxicating liquor, drug or narcotic at the time of accident? ☐ Yes ☐ No
9. Treatment given including follow up consultation :-

Date of consultation (dd/mm/yyy)	Treatment given	Healing Progress

10. Details of Hospitalization

Name of Hospital	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)	Type of Surgery Performed	Date of Surgery (dd/mm/yyyy)	Other Diagnosis Procedures or Treatment

11. Was the patient referred to you by any doctor? ☐ Yes ☐ No
    i. If yes, please indicate the name of doctor and address of the clinic / hospital.

    ……
    ii. Please attach a copy of the referral letter, if any.

12. Date of full weight bearing ..... (dd/mm/yyyy)

13. Was the healing complicated, eg: infection, malunion etc? ☐ Yes ☐ No

    i. If yes, please give details of complications……

14. Did the patient suffer amputation of limbs? ☐ Yes ☐ No

    i. If yes, please stated level of amputation seen (proximal, middle, distal)

    ……

15. Last date of consultation..... (dd/mm/yyyy)

16. Condition of healing / recovery of the injury / illness as at last consultation date

    ……

17. Did the patient suffer any loss of use of limbs and /or fingers? ☐ Yes ☐ No

    Please state the power of patient's upper and lower limbs as at last consultation date

    i. Right Upper Limb : …….. Right Lower Limb :……..

    ii. Left Upper Limb : …….. Left Lower Limb : ……..

18. Did the patient suffer any loss of eyes? ☐ Yes ☐ No

    Please give details on patient's Visual Acuity as at last consultation; (i) Right eye : …….. (ii) Left eye : ……..

19. Did the patient suffer any loss of hearing? ☐ Yes ☐ No

    Please give details on patient's hearing as at last consultation, (i) Right ear : ……db (ii) Left ear ..... db

20. Does the patient suffer any limitation of movement on any joint as at last consultation date? ☐ Yes ☐ No

    i. If yes, please state the limitation and range of movement

    ……

21. Please state the percentage(%) of whole person impairment according to AMA guidelines (completed by Specialist)

    ……

22. If the patient was diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him / her starting from the **first** recording done :

	Date (dd/mm/yyyy)	**Readings of Blood Pressure**		**Date (dd/mm/yyyy)**	**Results for Blood Glucose (Fasting)**
i.	……	……	i.	……	……
ii.	……	……	ii.	……	……

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : _____

Name of Doctor : _____ Qualification : _____

Telephone No. : _____ Fax No. : _____

Date : _____ (dd/mm/yyyy)

Official Stamp of Doctor : Name and Address of Clinic / Hospital Official Stamp

_____ _____