



## Life Insurance

### PERMANENT PARTIAL DISMEMBERMENT - STATEMENT OF MEDICAL EXAMINER

#### SECTION B

- 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.
- Expenses incurred to obtain this report will be borne by the Life Assured.

Policy No: .....

- Name of Patient: .....
- NRIC No. : ..... BC / Old IC No. : ..... Age: .....
- Occupation as indicated to you : .....
- Date of **first** consultation with you: ..... (dd/mm/yyyy) Time ..... (am/pm)
- Diagnosis: .....
- Date of diagnosis ..... (dd/mm/yyyy)
- What was the underlying cause and pathology of the above diagnosis?  
.....
- If the cause was due to accident, please state
  - Date of Accident : ..... (dd/mm/yyyy) Time ..... (am/pm)
  - Describe in detail the nature of accident as related to you by the patient:  
.....
  - Was the patient under the influence of intoxicating liquor, drug or narcotic at the time of accident? ☐ Yes ☐ No
- Treatment given including follow up consultation :-

| Date of consultation<br>(dd/mm/yyyy) | Treatment given | Healing Progress |
|--------------------------------------|-----------------|------------------|
|                                      |                 |                  |
|                                      |                 |                  |
|                                      |                 |                  |
|                                      |                 |                  |
|                                      |                 |                  |

#### 10. Details of Hospitalisation

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

- Was the patient referred to you by any doctor? ☐ Yes ☐ No
  - If yes, please indicate the name of doctor and address of the clinic / hospital.  
.....
  - Please attach a copy of the referral letter, if any.

12. Date of full weight bearing .....(dd/mm/yyyy)
13. Was the healing complicated, e.g.: 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:
- | <u>Date (dd/mm/yyyy)</u> | <u>Readings of Blood Pressure</u> | <u>Date (dd/mm/yyyy)</u> | <u>Results for Blood Glucose (Fasting)</u> |
|--------------------------|-----------------------------------|--------------------------|--------------------------------------------|
| 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 : \_\_\_\_\_

Telephone No. : \_\_\_\_\_

Date : \_\_\_\_\_(dd/mm/yyyy)

Official Stamp of Doctor :

Qualification : \_\_\_\_\_

Fax No. : \_\_\_\_\_

Name and Address of Clinic / Hospital Official Stamp