Life Insurance

ACCIDENT - 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 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 Accident : …… (dd/mm/yyyy) Time.....(am/pm)
5. Date of **first** consultation with you: …….. (dd/mm/yyyy) Time.....(am/pm)
6. Describe in detail the nature of accident as related to you by the patient:

   .....
7. Were there any external and visible injuries or wound as a result of this accident? ☐ Yes ☐ No
   i. If yes, please describe the extent of injuries including site and other characteristics, features as seen by you.

   ……
   ii. If no, please describe any other evidence that is consistent with the accident as claimed by the patient.

   ……
8. Treatment given including follow up visits (eg: number of stitches, types of dressing, surgical operations, etc)

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

9. Was the patient referred to you by other 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.
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. Stitches removed on.....(dd/mm/yyyy)
12. Date of commencement of medical leaves.....(dd/mm/yyyy)
13. Date of expiry of medical leaves.....(dd/mm/yyyy)
14. Number of days of light duty: ……

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

16. Was the patient under the influence of intoxicating liquor, drug or narcotic at the time of accident? ☐ Yes ☐ No

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

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

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

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

    ……

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

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

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

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

    ……

22. 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

    ……

23. Does the patient suffer any loss of use of limbs or /and fingers as at last consultation date ? ☐ Yes ☐ No

    If yes, 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 :……..

24. Was there any physical defect, illness or medical history which may have contributed to the accident and/or prolonged the disability? ……..

25. Does the patient suffer from any permanent disablement or physical defect as a result of this accident? ☐ Yes ☐ No

    i. If yes, please describe……

26. 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

_____ _____