TOTAL & PERMANENT DISABILITY CLAIM - STATEMENT OF MEDICAL EXAMINER (GROUP)

SECTION B

1. Section B is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries sustained or illnesses diagnosed.
2. Completion of Section B must be done **six months** after the diagnosis date.
3. Expenses incurred to obtain this report will be borne by the Participant.

CONTRACT NO:……

Name of Participant:……..……..

NRIC/Birth Cert No/Passport No: ……..

1. Are you the Participant's regular doctor? ☐ Yes ☐ No If yes, since what date ?.....(dd/mm/yyyy)

2. a. Date of **first** consultation for the current condition: ……(dd/mm/yyyy)

   b. Date(s) of subsequent consultation(s)

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

   c. Please state the symptoms presented and date symptoms **first** appeared

Symptoms presented at first consultation	Date symptoms first started (dd/mm/yyyy)

   i) What is the source of this information? ☐ Participant ☐ Referring Doctor ☐ Others If "Others", please specify the name of the person and relationship to the Participant.

   ……

   d. Diagnosis:……..

   ……

   ……

   e. Date of **first** diagnosis: ……(dd/mm/yyyy)

   f. Diagnosis was **first** made by (name of doctor):……(dd/mm/yyyy)

   g. Date diagnosis was made known to the Participant:……..(dd/mm/yyyy)

   h. What was the exact information conveyed to the Participant?

   ……...

3. a. Participant's occupation before disability:……

   b. Nature of duties of current occupation:……

   ……

c. How does the Participant's disability prevent him from performing the above listed duties of his/her occupation?

……

……

4.a. Is the condition a result of an accident? ☐ Yes ☐ No

If yes, please state the date of accident:……..(dd/mm/yyyy) ; Time of accident:……..(am/pm)

Describe in detail how the accident happened.

……...

……...

……...

b. Was the accident reported to the police? ☐ Yes ☐ No

If yes, please provide the name of the police division and the police officer-in-charge's name.

……

……

(Please enclose a copy of the police report)

c. Was the Participant under the influence of alcohol/drugs at the time of accident? ☐ Yes ☐ No

If yes, please state the blood alcohol content/drug type and quantity consumed:

……

d. Is the condition self-inflicted? ☐ Yes ☐ No If yes, please provide full details:

……

……

e. Type of treatment including any operations performed and his/her response.

……...

……

5. **Last date of consultation**: …… (dd/mm/yyyy). (Must be within 2 months from the completion of this form)

6. a. Please describe the full nature and severity of the Participant's disabilities.

……

……

b. Is his /her disability progressing, stagnant or recovering?

……

c. Is full recovery expected? ☐ Yes ☐ No If yes, please state approximate date: ……..(dd/mm/yyyy)

If no, please state the extent of recovery and approximate date of the stated extent of recovery

……

……

d. Is the Participant able to perform all the 6 Activities of Daily Living (ADL) without assistance?

Activities of Daily Living	Participant able to perform	
Transfer	Yes	No
Mobility	Yes	No
Continence	Yes	No
Dressing	Yes	No
Bathing/Washing	Yes	No
Eating	Yes	No

e. Is Participant confined to a home/hospital or other institution that provides constant care and medical attention?

☐ Yes ☐ No If yes, since what date:…….. ..(dd/mm/yyyy)

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

Please state the power of patient's upper and lower limbs

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

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

g. Did the patient suffer amputation of limbs or/and fingers? ☐ Yes ☐ No

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

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

Please give details on Insured's Visual Acuity; (i) Right eye : …… (ii) Left eye : ……

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

If yes, please give details on Insured's hearing, (i) Right ear : ……...db (ii) Left ear : ……db

j. Please give full details with respect to the Participant's mental abilities and cognition.

……

……

k. Is the Participant able to perform all the normal duties of his/her usual occupation? ☐ Yes ☐ No

If yes, when is he/she expected to return to his usual occupation? ……(dd/mm/yyyy)

l. If Participant is unable to return to his/her usual occupation, is he/she able to engage in any other occupation?

☐ Yes ☐ No If yes, what type of occupation can he/she be engaged in?

……

m. When is Participant expected to engage in these occupations? ……..……(dd/mm/yyyy)

7. a. Did the Participant consult other doctors for this condition or its symptoms BEFORE he/she consulted you?

☐ Yes ☐ No If yes, please give name(s) and address(es) of the doctor(s) whom he/she consulted.

Name of Doctor	Name of Clinic/Hospital and Address	Date of First Consultation (dd/mm/yyyy)

b. Is the Participant suffering or has suffered from any other significant illnesses?

☐ Yes ☐ No If yes, please state.

Illness /Diagnosis	Date of First Diagnosis (dd/mm/yyyy)	Name and Address of Attending Doctor

c. i. Is the Participant physically or mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

Please explain:

ii. If yes, when did such disability commence? ……..(dd/mm/yyyy)

d. Is the Participant terminally ill? ☐ Yes ☐ No

8. If the incapacity of the Participant cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future? ☐ Yes ☐ No

If yes, what is the appropriate time period for the Company to re-assess this claim? ……..(dd/mm/yyyy)

9. Please provide us with any other additional information that will enable the Company to assess this claim. Enclose copies of laboratory tests results, if any.

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……...

……...

DECLARATION:

I,…….. the undersigned, do hereby declare the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company. Furthermore, I certify that I have personally examined the identity of the above-named Participant and the facts as stated above represent my medical opinion of his/her condition.

…… ……

Signature of the Attending Physician Date (dd/mm/yyyy)

…… ……

Name of the Attending Physician Contact No.

…….. ……

Professional Qualification Official Stamp and Address