



Living Benefit Claim - Doctor's Statement
Congenital Illnesses Benefit – Congenital Diaphragmatic Hernia / Tracheo-esophageal Fistula or Esophageal Atresia

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

A) Patient's Particulars									
Name of Patient	Gender								
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
B) Patient's Medical Records									
1) Please state over what period does the Hospital/Clinic's record extend?									
(i) Date of First consultation (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(ii) Date of Last consultation (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(iii) Number of consultations during the above period:									
(iv) Name of hospital/clinic and Reasons for consultations (with dates):									
2) Are you the patient's usual medical doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", since when? (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
If "No", please provide name and address of the patient's regular doctor.									
3) Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please advise:									
(i) Date referred (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(ii) Reason the patient was referred:									
(iii) Name and address of doctor recommending the referral:									
If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E.)									
4) Have you referred the patient to any other doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No									
(i) Date referred (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(ii) Reason for referral:									
(iii) Name and address of doctor referred to:									

5) Does the patient have or ever have had any significant health conditions, medical history, any illness or any congenital condition? Yes No
 If "Yes", please advise:
Details of symptoms Exact diagnosis Date diagnosed Treatment

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

C) Details of Illness

1) Please provide details of the condition.

(i) Date the patient **First** consulted you for the condition (ddmmyyyy)

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(ii) Details of symptom(s) presented at **First** consultation

(iii) Date of onset of these symptoms (ddmmyyyy):

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(iv) **Final** Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of **First** diagnosis (ddmmyyyy)

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(vi) Date the patient **First** became aware of the condition (ddmmyyyy)

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2) Was the patient diagnosed of **Diaphragmatic Hernia**? Yes No
 If "No", please proceed to **question 3**.

(i) Was there presence of abdominal organs in the chest cavity at birth? Yes No
 (ii) Was there finding of herniated abdominal content into the thorax in chest-radiograph or other Investigation reports? Yes No
 If "Yes", please advise:
Date of Test/Investigations (ddmmyyyy) Test/Investigation reports Results

(iii) Was there surgical treatment undertaken for the treatment of Diaphragmatic Hernia? Yes No

If "Yes", please advise:

(a) Date of Operation (ddmmyyyy):

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(iv) Was the Diaphragmatic Hernia associated with pulmonary hypoplasia? Yes No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy) Test/Investigation reports Results

(v) Was the Diaphragmatic Hernia associated with underdeveloped heart? Yes No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy) Test/Investigation reports Results

(vi) Was the Diaphragmatic Hernia detected during pregnancy period of patient's mother? Yes No

If "Yes", please advise:

(a) Date of Diaphragmatic Hernia detected during pregnancy period of patient's mother (ddmmyyyy):

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(b) Date the patient's mother **First** became aware of Diaphragmatic Hernia detected during pregnancy period (ddmmyyyy):

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3) Was the patient diagnosed of **Tracheo-esophageal Fistula**? Yes No

If "No", please proceed to **question 4**.

(i) Was there abnormal opening between the trachea and esophagus? Yes No

(ii) Was the Tracheo-esophageal Fistula supported by echocardiogram? Yes No

If "Yes", please advise:

Date of Test/Investigations (ddmmyyyy) Test/Investigation reports Results

(iii) Was the Tracheo-esophageal Fistula a congenital disease? Yes No

If "No", please advise:

(a) What is the underlying cause?

(iv) Was there surgery done to correct Tracheo-esophageal Fistula? Yes No

If "Yes", please advise:

(a) Date of Operation (ddmmyyyy):

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(v) Was the Tracheo-esophageal Fistula detected during pregnancy period of patient's mother? Yes No

If "Yes", please advise:

(a) Date of Tracheo-esophageal Fistula detected during pregnancy period of patient's mother (ddmmyyyy):

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(b) Date the patient's mother **First** became aware of Tracheo-esophageal Fistula detected during pregnancy period (ddmmyyyy):

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4) Was the patient diagnosed of **Esophageal Atresia**? Yes No

If "No", please proceed to **question 5**.

(i) Was there failure of the esophagus to develop as a continuous passage and it ends as a blind pouch? Yes No

(ii) Was the Esophageal Atresia supported by echocardiogram? Yes No

If "Yes", please advise:

<u>Date of Test/Investigations (ddmmyyyy)</u>	<u>Test/Investigation reports</u>	<u>Results</u>
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(iii) Was the Esophageal Atresia a congenital disease? Yes No

If "No", please advise:

(a) What is the underlying cause?

(iv) Was there surgery done to correct Esophageal Atresia? Yes No

If "Yes", please advise:

(a) Date of Operation (ddmmyyyy):

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(v) Was the Esophageal Atresia detected during pregnancy period of patient's mother? Yes No

If "Yes", please advise:

(a) Date of Esophageal Atresia detected during pregnancy period of patient's mother (ddmmyyyy):

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(b) Date the patient's mother **First** became aware of Esophageal Atresia detected during pregnancy period (ddmmyyyy):

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5) Was this pregnancy conceived through any of the following fertility treatments:

- (a) Vitro Fertilization (**IVF**) Yes No
- (b) Intra-Cytoplasmic Sperm (**ICSI**) Yes No
- (c) Intrauterine Insemination (**IUI**) Yes No
- (d) Intracervical Insemination (**ICI**) Yes No
- If none of the above, please specify the fertility treatment that the patient has received:

6) Was the patient's mother carrying 5 or more babies in this pregnancy? Yes No
If "No", please state the **number** of babies that the patient has carried in this single pregnancy.

7) Is the diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? Yes No

If "Yes", please state:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):

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Date the patient **First** became aware of the condition (ddmmyyyy):

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If "Yes", please provide the details including name of doctor and clinic who first diagnosed the patient with HIV or AIDS, Please provide copy of test result.

- 8) Is the diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by:
- (i) self-inflicted illness, injury, suicide or attempted suicide? Yes No
- (ii) deliberate misuse of alcohol? Yes No
- (iii) deliberate misuse of drugs? Yes No
- (iv) use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? Yes No

9) Please provide us with any other additional information that will enable the Company to assess this claim.

10) Please enclose a copy of all investigation reports including specialist reports, hospital reports, laboratory reports and etc that are available.

- (i) Computerised tomography scan (CT scan)
- (ii) Magnetic resonance imaging (MRI), other imaging studies
- (iii) Ultrasound reports
- (iv) X-Ray
- (v) Operation reports, surgical reports
- (vi) Referral letters (if any)
- (vii) Any other investigation reports

D) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor	Address & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	