Living Benefit Claim - Doctor's Statement
Pre-Eclampsia or Eclampsia

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) | | | | | | | | |

B) Patient's Medical Records

1) Please state over what period does the Hospital/Clinic's record extend?

(i) Date of **First** consultation (ddmmyyyy) | | | | | | | | |

(ii) Date of **Last** consultation (ddmmyyyy) | | | | | | | | |

(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? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy) | | | | | | | | |

If "No", please provide name and address of the patient's regular doctor.

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date referred (ddmmyyyy) | | | | | | | | |

(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? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy) | | | | | | | | |

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

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5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. tumour, diabetes, hypertension, hyperlipidaemia, anaemia etc.)? ❒ 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?

8) Please give details of the patient's habits in relation to past and present **smoking**, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

No. of years of smoking	No. of sticks per day	Source of information

9) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of the alcohol consumption, frequency, and the source of this information.

Type of alcohol	Quantity per Consumption	Frequency (per week / month, etc.)	Source of information

C) Details of Illness

1) Please provide details of the condition:

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

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

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

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

ICD-10 Code (if applicable):

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

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

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2) Please provide full details and results of all **investigation** performed (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports.

3) Name and address of the doctor who **First** diagnosed the patient with the diagnosis.

4) Was there hypertension developing after 20 weeks of pregnancy? ❒ Yes ❒ No

5) What were the highest Blood Pressure readings recorded on 2 successive measurements of at least 6 hours apart post 20 weeks of pregnancy? ❒ Yes ❒ No

If "Yes", please advise:

(i) **First** Reading Taken: Date (ddmmyyyy), time and its reading

Time: _____ Systolic:_____mmHg

Diastolic:_____ mmHg

(ii) Next Reading Taken: Date (ddmmyyyy), time and its reading

Time: _____ Systolic:_____mmHg

Diastolic:_____ mmHg

6) Was there associated proteinuria of more than 3+ on a random urine sample? ❒ Yes ❒ No
If "Yes", please advise the details and reading:

If "No",

(i) Was there associated proteinuria of more than 1+ on a random urine sample? ❒ Yes ❒ No
If "Yes", please advise the details and reading:

7) Was there protein/creatinine ratio > 0.3 mg/mg on a random urine sample? ❒ Yes ❒ No
If "Yes", please advise the details and reading:

8) Please state the number of gestational weeks before the birth of the baby.

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

(i) Vitro Fertilization (**IVF**) ❒ Yes ❒ No

(ii) Intra-Cytoplasmic Sperm (**ICSI**) ❒ Yes ❒ No

(iii) Intrauterine Insemination (**IUI**) ❒ Yes ❒ No

(iv) Intracervical Insemination (**ICI**) ❒ Yes ❒ No

If none of the above, please specify the fertility treatment that the patient has received:

10) Was the patient 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.

11) Is the patient's diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by

(i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please provide details:

Date of Diagnosis of AIDS/HIV (ddmmyyyy): | | | | | | | | |

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

(ii) deliberate misuse of alcohol? ❒ Yes ❒ No

(iii) deliberate misuse of drugs? ❒ Yes ❒ No

(iv) self-inflicted illness, injury, suicide or attempted suicide? ❒ Yes ❒ No

(v) use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? ❒ Yes ❒ No

(vi) pregnancy complications from fertility treatments? ❒ Yes ❒ No

(vii) elective abortions? ❒ Yes ❒ No

(viii) complications arising from child delivery in overseas hospitals and hospitalisation occurring overseas? ❒ Yes ❒ No

If "Yes", please provide full details including reasons for the result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and Hospital/Clinic who **First** diagnosed the patient with HIV or AIDS, deliberate misuse of alcohol, deliberate misuse of drugs, use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner, pregnancy complications from fertility treatments, elective abortions or complications arising from child delivery in overseas hospitals and hospitalisation occurring overseas.

Please provide copy of test result.

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

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

(i) Blood test reports
(ii) Computerised tomography scan (CT scan)
(iii) Magnetic resonance imaging (MRI), other imaging studies
(iv) Ultrasound reports
(v) Urinalysis reports
(vi) X-Ray
(vii) Operation reports, surgical reports
(viii) Referral letters (if any)
(ix) 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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