



AFFIN



TOTAL & PERMANENT DISABILITY CLAIM FORM (BY DOCTOR)

Important Note :

Your patient is insured with us against the happening of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement. (For any medical report fee incurred in completing this form, it will be borne by the claimant)

Policy No

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Please attach the certified true copy of all the relevant tests available.

CT Scan / MRI X-ray Blood & Laboratory

1. Patient's Details

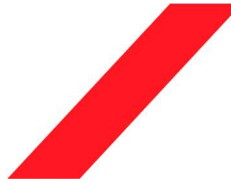
Full Name

NRIC / OLD IC / Passport No.

Occupation & exact duties

2. Medical Record

Date the patient first consulted you for this condition	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	DD	MM	YY	
Date(s) of subsequent condition(s) or follow-up(s)	<input type="text"/> <input type="text"/>			
The presenting sign(s) & symptom(s) during the first consultation with you				
Symptom		Date symptom first presented (dd/mm/yyyy)		
<input type="text"/>		<input type="text"/>		
<input type="text"/>		<input type="text"/>		
Please describe the full and exact diagnosis	Date when the illness FIRST diagnosed			
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
	DD	MM	YY	
Date when the patient FIRST became aware of the illness	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
	DD	MM	YY	
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	
	DD	MM	YY	



Did the patient consult other doctors for this condition or its symptom **BEFORE** he / she consulted you? YES NO
 If YES, please provide the following :

Name of Doctor	Name of Clinic / Hospital and Address	Date of Consultation

3. If disability caused by Accident

Is the condition a result by Accident <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, please state the date of accident : <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY	Describe in detail how the accident happened : _____ _____ _____
Was the patient under the influence of alcohol? <input type="checkbox"/> YES <input type="checkbox"/> No		If YES, please state the blood alcohol content / drug type and quantity consumed. _____ _____
Is the condition self-inflicted? <input type="checkbox"/> YES <input type="checkbox"/> No		If YES, please provide the full details : _____ _____ _____

4. Latest detail examination

Last examination / consultation date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY	Please describe fully the nature of the patient's disabilities : _____ _____																								
<table border="1"> <thead> <tr> <th>Vision (Visual Acuity)</th> <th>Right</th> <th>Left</th> </tr> </thead> <tbody> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on Metric Acuity</td> <td> </td> <td> </td> </tr> </tbody> </table>	Vision (Visual Acuity)	Right	Left	Normal			Impaired			Scores based on Metric Acuity			<table border="1"> <thead> <tr> <th>Hearing</th> <th>Right</th> <th>Left</th> </tr> </thead> <tbody> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on Speech Reception threshold</td> <td>dB</td> <td>dB</td> </tr> </tbody> </table>	Hearing	Right	Left	Normal			Impaired			Scores based on Speech Reception threshold	dB	dB
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Examination of Limbs' Muscle Power and Range of Movement of the various joints in the table below with maximum grade of 5

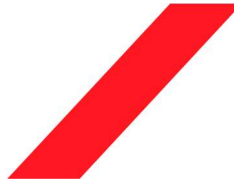
Joints	Muscle of Power		Range of Movement	
	Right	Left	Right	Left
Shoulder				
Elbow				
Wrist				
Grip				
Hip				
Knee				
Ankle				

Assessment of Activities of Daily Living (ADL)

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer (Getting in & out a chair without physical assistance)			
Mobility (Ability to move from room to room without physical assistance)			
Continence (Ability to voluntarily control bowel & bladder function to maintain personal hygiene)			
Dressing (Putting on & taking all necessary items of clothing without assistance)			
Bathing & Washing (Ability to wash & shower, including getting in & out of bath or shower by any other means without assistance)			
Eating (All task of getting food into the body without assistance)			

What is patient's disability? <input type="checkbox"/> Progressively worsening <input type="checkbox"/> Stagnant <input type="checkbox"/> Recovering	Is fully recovery expected? Please state expected period needed <input type="checkbox"/> YES _____ <input type="checkbox"/> NO _____
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Is the patient able to perform all the normal duties of his / her occupation?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, when is he / she expected to return to his / her occupation? <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY
If he / she unable to return to his / her usual occupation, is he / she able to engage in any other occupation? <input type="checkbox"/> YES <input type="checkbox"/> NO	What types of occupation can he / she engaged in? _____ _____	When is he / she expected to engage in these occupations? <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY
Is the patient physically or mentally incapacitated from ever continuing in any employment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, when did such disability commence? <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY
Is the patient certified to be TOTAL & PERMANENT DISABLED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, when is the certification date? <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY
If the capacity of the patient CANNOT be confirmed upon examination or ascertained, would you recommend next review date?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, when is the next review / assessment date ? <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY



5. Declaration & Authorization

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declaration of this claim form.

Name :

Address :

Signature and Official Stamp

Date :