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)

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

Policy No

			-							
			-							

☐ 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	DD MM YY
Date(s) of subsequent condition(s) or follow-up(s)	_____ _____

The presenting sign(s) & symptom(s) during the first consultation with you

Symptom	Date symptom first presented (dd/mm/yyyy)

Please describe the full and exact diagnosis _____ _____	Date when the illness FIRST diagnosed DD MM YY
Date when the patient FIRST became aware of the illness DD MM YY	Date when diagnosis first made to the patient 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 ☐ YES ☐ NO	If YES, please state the date of accident : DD MM YY	Describe in detail how the accident happened : _____ _____ _____
Was the patient under the influence of alcohol? ☐ YES ☐ No		If YES, please state the blood alcohol content / drug type and quantity consumed. _____ _____
Is the condition self-inflicted? ☐ YES ☐ No		If YES, please provide the full details : _____ _____ _____

4. Latest detail examination

Last examination / consultation date

DD MM YY

Please describe fully the nature of the patient's disabilities :

_____

_____

Vision (Visual Acuity)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity		

Hearing

	Right	Left
Normal		
Impaired		
Scores based on Speech Reception threshold	dB	dB

Function of Speech

Clear and Understandable	
Slurred	
Unable to Speech	

Cognitive Function

Normal	
Poor Comprehension	
Difficulty with logic and reasoning	
Memory loss	

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 assistance)	(Ability to move from room to room without physical	☐	☐	☐
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?

☐ Progressively worsening
☐ Stagnant
☐ Recovering

Is fully recovery expected?

Please state expected period needed

☐ YES _____
☐ NO _____

Is the patient able to perform all the normal duties of his / her occupation?	☐ YES ☐ NO	If YES, when is he / she expected to return to his / her occupation? ☐☐ DD ☐☐ MM ☐☐ YY
If he / she unable to return to his / her usual occupation, is he / she able to engage in any other occupation? ☐ YES ☐ NO	What types of occupation can he / she engaged in? _____ _____	When is he / she expected to engage in these occupations? ☐☐ DD ☐☐ MM ☐☐ YY
Is the patient physically or mentally incapacitated from ever continuing in any employment?	☐ YES ☐ NO	If YES, when did such disability commence? ☐☐ DD ☐☐ MM ☐☐ YY
Is the patient certified to be TOTAL & PERMANENT DISABLED?	☐ YES ☐ NO	If YES, when is the certification date? ☐☐ DD ☐☐ MM ☐☐ YY
If the capacity of the patient CANNOT be confirmed upon examination or ascertained, would you recommend next review date?	☐ YES ☐ NO	If YES, when is the next review / assessment date ? ☐☐ 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 :