* S U P D O C *

Singlife with AVIVA

Living Benefit Claim - Doctor's Statement
Pregnancy Complications Benefit – Disseminated Intravascular Coagulation

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)

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 provide:

(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 provide:

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 **Disseminated Intravascular Coagulation ("DIC")** Condition.

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

(ii) Details of symptom(s) presented at first consultation, and date these symptoms **first** started.

(iii) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

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

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

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2) Did DIC occur as a result of pregnancy? If "No", please provide details. ❒ Yes ❒ No

3) Did DIC occur within the first 7 months of pregnancy? ❒ Yes ❒ No

4) Please state if the following were present:

(a) Over activation of the coagulation and fibronolytic system ❒ Yes ❒ No

(b) Microvascular thrombosis ❒ Yes ❒ No

(c) Consumption of platelets and coagulation factors ❒ Yes ❒ No

(d) Major haemorrhage ❒ Yes ❒ No

(e) Treatment with frozen plasma and platelet concentrates ❒ Yes ❒ No

Please provide copy of the investigation results to support the diagnosis.

5) What is the underlying cause(s) of the DIC?

6) 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

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

7) 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.

8) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ❒ Yes ❒ No

If "Yes", please provide the date of HIV/AIDS diagnosis (dd/mm/yyyy) | | | | | | | | |

9) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide? ❒ Yes ❒ No

10) Is the diagnosis related to any deliberate misuse of any drugs or alcohol? ❒ Yes ❒ No

11) Is the diagnosis related to the use of unprescribed drugs where such drugs are required by the law to be prescribed by a registered medical doctor? ❒ Yes ❒ No

12) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.

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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)	