* S U P D O C *

Singlife with AVIVA

Living Benefit Claim - Doctor's Statement
Congenital Illnesses Benefit – Cleft Lip and Cleft Palate

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, any illness or any congenital condition? If "Yes", please provide: ❒ Yes ❒ No

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 **Cleft Lip and Cleft Palate** 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) | | | | | | | | |

2) Has surgery been perform to correct the condition? ❒ Yes ❒ No

If "Yes", please provide date of surgery (ddmmyyyy) and provide a copy of the operation report.

3) What is the underlying cause(s) of the condition?

4) 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:

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5) Was the patient's mother carrying 5 or more babies in this pregnancy? If "No", please state the **number** of babies that the patient has carried in this single pregnancy.	❒ Yes ❒ No
6) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide the date of HIV/AIDS diagnosis. (dd/mm/yyyy)	❒ Yes ❒ No ☐☐☐☐☐☐☐☐
7) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	❒ Yes ❒ No
8) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	❒ Yes ❒ No
9) 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
10) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.	

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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