

3. PATIENT'S CONDITION

(a) Please describe fully the nature and severity of the patient's current disability.

(b) Is the patient confined to a home, hospital or similar institution that provides constant care and medical attention? Yes No

(c) Please comment on the patient's range of movement.

(d) Does the patient have full power of all limbs? Yes No

If no, please state which limb(s) do(es) not have full power and the corresponding muscle power?

(e) What is the likelihood of improvement in motor function over time?

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(g) Please provide full details with respect to the patient's mental abilities and cognition.

(h) Please describe the past and current treatment provided, including any operations performed and whether it is likely to improve his/her condition.

(i) Is the patient compliant with the recommended treatment program? Yes No
If no, please elaborate.

(j) What treatment is planned for the future?

(k) How often must the patient be on follow-up for this condition?

(l) Please provide all duties of the patient's usual occupation, including percentage of time spent in each.

Duties	Percentage%
<hr/>	<hr/>
<hr/>	<hr/>

(m) Please provide full details of the patient's capabilities and limitations in relation to his/her usual occupation.

Capabilities (What the patient can do)

Limitations (What the patient cannot do)

(n) Is the patient able to perform all the normal duties of his/her usual condition?

Yes No

If yes, when is he/she expected to return to his usual occupation.

_____ / _____ / _____
 dd mm yyyy

If no, when did he/she cease all work.

_____ / _____ / _____
 dd mm yyyy

(o) If the patient is **unable** to return to his/her usual occupation, is he/she able to engage in any occupation? Yes No

If yes, please provide us with the following details.

(i) What type of occupation can he/she engage in?

(ii) When is he/she expected to engage in these occupations?

_____ / _____ / _____
 dd mm yyyy

(p) In your opinion, is the patient **totally and permanently disabled** as a result of bodily injury or disease and is **unable to engage in any occupation** or whatsoever **or perform any work for income or profit** currently or at anytime thereafter. Yes No

If yes, please provide information such as relationship to insured, nature of illness, date of diagnosis and source of information.

- (d) Did the patient consult other doctors for this illness or its symptoms before he/she consulted you? Yes No

If yes, please provide the name(s) and addresses(es) of the doctor(s) who he/she consulted.

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

- (e) Is the patient suffering or has suffered from any other significant illnesses? Yes No

If yes, please provide the following information to us:

Name of Doctor	Name and Address of Clinic/Hospital	Diagnosis Date and Illness

- (f) Please give any other information, which you feel would be helpful in assessment of the patient's claim.

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

I hereby certify that the above statements are true and complete to the best of my knowledge and belief.

_____ Signature Over Printed Name of Physician	_____ Date Signed
_____ Qualification	_____ Address
_____ PRC Number / PTR Number	_____ Telephone Number (s)

To the Attending Physician : You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.