# GROUP CRITICAL ILLNESS CLAIM FORM

Dear insured employee / spouse or child ("life insured"),

We are sorry to learn about your illness.

In order for us to process your claim, we require the following:

(1) Group Critical Illness Claim Form
(2) Group Critical Illness Claim Medical Report (medical fee to be borne by life insured)
(3) Copy of NRIC / Passport of life insured (to be certified by Employer)
(4) Consent Form for Medical Report
(5) Histopathological / biopsy reports (for cancer)
(6) ECG reading & enzymes assays (for heart attack)
(7) CT scan / MRI scan results (for stroke)
(8) Available laboratory and test results

Once we have received **all** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

**Note:**
This form is to be completed for making a claim of benefits under Dread Disease / Critical Illness and Terminal Illness.

# GROUP CRITICAL ILLNESS CLAIM FORM

RINE INSURANCE GROUP

**IMPORTANT NOTES :**

(1) The issue of this claim form is not an admission of liability.
(2) This claim form is to be completed by life insured.
(3) Tokio Marine Life Insurance Singapore Ltd. reserves the right to request for additional medical reports when it deems necessary.

## PART 1 : TO BE COMPLETED BY THE EMPLOYER / COMPANY

Name of employer: _____ Group policy no: _____

Name of employee: _____ Subsidiary / cost centre: _____

NRIC / Passport no.: _____ Gender: ☐ Male ☐ Female

Date of birth: _____ Marital status: _____ Designation: _____

Date of employment (dd/mm/yyyy): _____ Plan: _____

**Personal Data Notice**

We represent, warrant and undertake that collective consents have been obtained from each of our employees and their respective life assureds and/or dependents, to allow Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd ("Tokio Marine Insurance Group") to collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form or Tokio Marine Insurance Group's Data Protection Policy available at www.tokiomarine.com, which we / they have read, understood and agreed to the same.

_____ _____

Company's Stamp and Authorized Signature Date (dd/mm/yyyy)

Name: _____ NRIC / Passport No. _____

Designation: _____ Email: _____

## TO BE COMPLETED BY PATIENT

***PART 2 : DETAILS***

Name of patient : _____

Relationship to employee : _____

NRIC No. / Passport no. : _____ Date of birth : _____

Occupation : _____ Gender: ☐ Male ☐ Female

***PART 3 : DETAILS OF CLAIM***

3.1 Describe fully the symptoms & resulting diagnosis :

_____

3.2 Date when did you **first** consulted a doctor for the above symptoms : _____ (dd/mm/yyyy)

3.3 How long did you have the symptoms before he / she consulted a doctor?

_____

3.4 Describe fully the nature and extent of your illness :

_____

_____ _____

Signature of life insured
(to be signed by patient's parent or legal guardian if patient is below 21 years old)

Date (dd/mm/yyyy)



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3.5 If consultation was due to an accident, describe fully the nature of your injuries and how it happened :

3.6 Have you previously suffered from or received treatment for a similar / related illness? ☐ Yes ☐ No
If **yes**, please provide details :

3.7 Have you been treated or diagnosed for this condition outside Singapore? ☐ Yes ☐ No
If **yes**, please provide details :

3.8 Please provide details of doctor(s) whom you have consulted in connection to your illness :

| Name of doctor / hospital | Address | Date of first consultation / hospitalisation |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

3.9 Please provide details of your regular doctor(s), date and reason(s) of consultation :

| Name of doctor | Address | Date of consultation | Reason(s) of consultation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Signature of life insured
(to be signed by patient's parent or legal guardian if patient is below 21 years old)

Date (dd/mm/yyyy)



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TOKIO MARINE
INSURANCE GROUP

***PART 4 : OTHER INSURANCES***

4.1 Are you insured with other insurance company(ies)? ☐ Yes ☐ No

If **yes**, please provide the following details :

| Name of insurance company | Date of issue | Sum insured | Type of plan | Claim amount | Claim notified |
|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

**Personal Data Notice**

I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd ("Tokio Marine Insurance Group") may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or the Tokio Marine Insurance Group's Data Protection Policy available at www.tokiomarine.com which I / we have read, understood and agreed to the same.

**Declaration**

I / We declare that all answers given by me / us in this form are, to the best of my / our knowledge and belief, true and complete.

I / We hereby also authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by the Tokio Marine Insurance Group, any relevant information concerning the below-named assured, and;

(b) the Tokio Marine Insurance Group to release to any medical source, insurance office, or organization, any relevant information concerning the below-named assured, at any time.

A photocopy of this authorization shall have the same effect as the original.

_____ _____

Signature of patient
(to be signed by patient's parent or legal guardian if patient is below 21 years old)

Date (dd/mm/yyyy)

Name of patient : _____

Address: _____

NRIC No.: _____ Relationship to employee: _____

Contact No(s) : _____ Email : _____



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TOKIO MARINE
INSURANCE GROUP

# GROUP CRITICAL ILLNESS CLAIM
# MEDICAL REPORT

**Name of Patient :** _____ **NRIC / Passport No :** _____
(as stated in NRIC / Passport)

**INSTRUCTIONS: Please tick [✓ ] in the appropriate box and complete the relevant sections in respect to the illness claimed. Please submit ONLY the relevant sections to us upon completion.**

| | | | Sections to be completed | | | | Sections to be completed |
|---|---|---|---|---|---|---|---|
| 1. | Major Cancers | ☐ | 1 & 10 | 20. | HIV Due To Blood Transfusion and Occupational Acquired HIV | ☐ | 1 & 23 |
| 2. | Stroke | ☐ | 1 & 9 | 21. | Loss of Independence Existence | ☐ | 1 & 4 |
| 3. | Heart Attack of Specified Severity | ☐ | 1 & 2 | 22. | Loss of Speech | ☐ | 1 & 25 |
| 4. | Coronary Artery By-pass Surgery / Angioplasty & Other Invasive Treatment for Coronary Artery | ☐ | 1 & 7 | 23. | Major Burns | ☐ | 1 & 26 |
| 5. | Kidney Failure | ☐ | 1 & 24 | 24. | Major Head Trauma | ☐ | 1 & 36 |
| 6. | Alzheimer's Disease / Severe Dementia | ☐ | 1 & 11 | 25. | Major Organ / Bone Marrow Transplantation | ☐ | 1 & 27 |
| 7. | Aplastic Anaemia | ☐ | 1 & 12 | 26. | Motor Neurone Disease | ☐ | 1 & 28 |
| 8. | Apallic Syndrome | ☐ | 1 & 3 | 27. | Multiple Sclerosis | ☐ | 1 & 29 |
| 9. | Bacterial Meningitis | ☐ | 1 & 13 | 28. | Muscular Dystrophy | ☐ | 1 & 30 |
| 10. | Benign Brain Tumour | ☐ | 1 & 14 | 29. | Paralysis (Loss Of Use Of Limbs) | ☐ | 1 & 31 |
| 11. | Blindness (Loss of Sight) | ☐ | 1 & 15 | 30. | Parkinson's Disease | ☐ | 1 & 32 |
| 12. | Coma | ☐ | 1 & 16 | 31. | Pericardial Disease | ☐ | 1 & 4 |
| 13. | Deafness (Loss of Hearing) | ☐ | 1 & 17 | 32. | Poliomyelitis | ☐ | 1 & 33 |
| 14. | | ☐ | | 33. | Primary Pulmonary Hypertension | ☐ | 1 & 34 |
| 15. | Viral Encephalitis | ☐ | 1 & 18 | 34. | Progressive Scleroderma | ☐ | 1 & 6 |
| 16. | End Stage Liver Disease | ☐ | 1 & 19 | 35. | Surgery To Aorta | ☐ | 1 & 8 |
| 17. | End Stage Lung Disease | ☐ | 1 & 20 | 36. | Systemic Lupus Erythematosus with Lupus Nephritis | ☐ | 1 & 35 |
| 18 | Fulminant Hepatitis | ☐ | 1 & 22 | 37. | Terminal Illness | ☐ | 1 & 21 |
| 19 | Heart Valve Surgery | ☐ | 1 & 5 | | | | |

**Please enclose copies of Histopathology / Biopsy Report (for Cancer), ECG Reading & Enzymes Assays (for Heart Attack), CT Scan / MRI Scan results (for Stroke and Benign Brain Tumour) and all laboratory and Test results, etc and any relevant hospital reports that are available.**

_____ _____
Signature of Attending Doctor | Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____ Date (dd/mm/yyyy) : _____



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## SECTION 1 : GENERAL INFORMATION

a Are you the patient's regular doctor? ☐ Yes ☐ No
If **Yes**, since :

_____
(dd/mm/yyyy)

If **No**, kindly provide the Name and Address of the patient's regular doctor (if known to you):

_____

b When did patient first consult you for this illness?

_____
(dd/mm/yyyy)

c Please state symptoms presented and the date symptoms first appeared as follows :

| Symptoms Presented | Date symptoms first started (dd/mm/yyyy) | Duration of symptoms |
|---|---|---|
| | | |
| | | |

d Please provide full and exact details of the diagnosis and its clinical basis.

_____

_____

e What is the date of diagnosis?

_____
(dd/mm/yyyy)

f What is the date when diagnosis was first made known to the patient?

_____
(dd/mm/yyyy)

g Has the patient previously suffered from the condition described above or any related illness? ☐ Yes ☐ No
If **Yes**, kindly provide the details below:

| Illness | Date of First Diagnosis (dd/mm/yyyy) | Name and Address of Attending Doctor |
|---|---|---|
| | | |
| | | |

h Is there anything in the patient's personal medical history or family history which would have increased the risk of the above illness? If yes, please give full details including the date of diagnosis and name & address of attending doctor. ☐ Yes ☐ No

_____

_____

i Is the patient suffering from other significant illness(es) / condition(s)? ☐ Yes ☐ No
If **Yes**, kindly provide the details below:

_____

_____

j Please give details of the patient's past and present smoking habits, including the duration and number of cigarettes smoked per day.

_____

_____
Signature of Attending Doctor

_____
Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____



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## SECTION 2 : HEART ATTACK OF SPECIFIED SEVERITY

a Please state the date where Heart Attack was first diagnosed _____ (dd/mm/yyyy)

b Was there a current history of chest pain and / or shortness of breath? ☐ Yes ☐ No

c Where there any changes in the ECG indicative of a myocardial infarction? ☐ Yes ☐ No

d Was there a serial elevation of cardiac enzymes documented? ☐ Yes ☐ No

e Was there a death of a portion of the heart muscle? ☐ Yes ☐ No

f Was there elevation of Troponin (T or I) documented? ☐ Yes ☐ No

g If **Yes**, please state = Troponin Reading : _____ Date : _____ (dd/mm/yyyy)

h Was left ventricular ejection fraction (LVEF) taken 3 months or more after the event? ☐ Yes ☐ No

i If **Yes**, please state = LVEF % : _____ Date : _____ (dd/mm/yyyy)

j Date of return to normal activities : _____ (dd/mm/yyyy)

## SECTION 3 : APALLIC SYNDROME

a Is there presence of universal necrosis of the brain cortex with the brainstem intact? ☐ Yes ☐ No
If **Yes**, describe the neurological damage.

b Did the appallic syndrome persist for at least one month since its onset? ☐ Yes ☐ No
If **Yes**, please state the duration for which it persisted:

c Is the patient's condition in any way related or due to AIDS or HIV related illness? ☐ Yes ☐ No
If **Yes**, please provide details.

## SECTION 4 : LOSS OF INDEPENDENT EXISTENCE

a Is the patient able to perform (whether aided* or unaided) for a continuous period of at least 6 months the followings:

(i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means ☐ Yes ☐ No

(ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances ☐ Yes ☐ No

(iii) Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No

(iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene ☐ Yes ☐ No

(v) Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

(vi) Ability to feed oneself once food has been prepared and made available ☐ Yes ☐ No

* Aided shall mean with the aid of special equipment, device and / or apparatus and not pertaining to human aid

Signature of Attending Doctor

Name & Qualification : _____

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____



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## SECTION 5 : HEART VALVE SURGERY

a What is the date of onset of the heart valve defects?

_____ (dd/mm/yyyy)

b Was surgery performed to repair or replace the heart valve abnormality? ☐ Yes ☐ No

c If Yes, please state the surgical procedure used to correct the valvular problem (i.e. open heart surgery, percutaneous intravascular balloon valvuloplasty with OR without thoracotomy etc)

_____

d What was the date of the surgery?

_____ (dd/mm/yyyy)

e Was there any deployment of :

(i) new valve ☐ Yes ☐ No

(ii) percutaneous device ☐ Yes ☐ No

(iii) prosthesis ☐ Yes ☐ No

f Has the patient suffered or is suffering from any related illnesses e.g. hypertension, vascular disease etc

_____

## SECTION 6 : PROGRESSIVE SCLERODERMA

a Please provide a description of the extent of the illness.

_____

_____

b Does the illness involve the followings:

(i) skin with deposits of calcium (calcinosis) ☐ Yes ☐ No

(ii) skin thickening of the fingers or toes (sclerodactyly) ☐ Yes ☐ No

(iii) the esophagus ☐ Yes ☐ No

(iv) telangiectasia (dilated capillaries) and Raynaud's Phenomenon causing artery spasms in the extremities ☐ Yes ☐ No

(v) heart ☐ Yes ☐ No

(vi) lungs ☐ Yes ☐ No

(vii) kidneys ☐ Yes ☐ No

c Please provide the results of investigations done and attach copy of the serology and biopsy report (if any)

_____

_____ Signature of Attending Doctor

_____ Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____



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## SECTION 7 : CORONARY ARTERY BY-PASS SURGERY / ANGIOPLASTY / CAD

a Please describe the full and exact diagnosis of the heart condition leading to surgery:

b Which are the coronary arteries involved and what is the degree of narrowing (%) in respect of each involved artery?

c Please state the type of surgery performed [i.e. Angioplasty, Coronary Artery By-Pass Surgery, 'Keyhole' surgery, Atherectomy, Transmycardial Laser Revascularisation, Enhanced External Counterpulsation or Minimally Invasive Direct Coronary Artery Bypass (MIDCAB)

d If a Coronary Artery By-Pass surgery was performed:

(i) please state the number of grafts and site of grafts inserted:

(ii) was open-heart surgery performed? ☐ Yes ☐ No

(iii) what is the date of the surgery?

_____ (dd/mm/yyyy)

e Please provide the name of surgeon who perform the surgery and the name & address of hospital where the surgery was performed

f Has the patient previously suffered from the above illnesses or any other cardiovascular diseases?

g Please give details of the patient's medical history which would have increased the risk of coronary artery disease (eg Hypertension, Hyperlipidaemia, Diabetes)

## SECTION 8 : SURGERY TO AORTA

a On what date did the patient first become aware of the condition necessitating surgery?

_____ (dd/mm/yyyy)

b What was the type of surgery performed?

c When was the surgery performed?

_____ (dd/mm/yyyy)

d Was excision and surgical replacement of the diseased aorta with a graft performed? ☐ Yes ☐ No

e Was the surgery performed using minimally invasive or intra arterial techniques? ☐ Yes ☐ No

f Was there enlargement of the aorta? ☐ Yes ☐ No

If **Yes**, please state the diameter of enlargement in millimetres:

g Has the patient suffered or is suffering from any related illnesses e.g. hypertension, angina, vascular disease, endocarditis etc

Signature of Attending Doctor

Name & Qualification : _____

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____



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## SECTION 9 : STROKE

a Please describe the episode:

(i) Date of episode _____ (dd/mm/yyyy)

(ii) Nature of the episode and duration of the acute symptoms:

_____

(iii) Is the patient able to resume normal activities?
If **Yes**, please state the date he/she has returned OR is expected to return to normal activities: _____ (dd/mm/yyyy)

(iv) If **No**, please state the patient's current physical and mental limitations and the date of your assessment:

| Date of Assessment | Neurological Limitations |
|---|---|
| | |
| | |

(v) When is the date of the patient's next review with you? _____ (dd/mm/yyyy)

b (i) Was there any evidence of neurological deficit 6 weeks after the date of stroke diagnosis? ☐ Yes ☐ No
If **Yes,** please provide details:

_____

(ii) Are these neurological deficits likely to be permanent? ☐ Yes ☐ No

(iii) Has there been an infarction of brain tissue, haemorrhage or embolisation from an extracranial source? ☐ Yes ☐ No

(iv) Are the investigations or findings consistent with the diagnosis of a NEW stroke? ☐ Yes ☐ No
If **Yes,** please provide details:

_____

c (i) Is this a Transient Ischaemic Attack? ☐ Yes ☐ No

(ii) Is the brain damage due to an accident or injury, infection, vasculitis or inflammatory disease? ☐ Yes ☐ No

(iii) Is the illness a vascular disease affecting the eye or optic nerve? ☐ Yes ☐ No

(iv) Is the current condition a result of ischaemic disorders of the vestibular system? ☐ Yes ☐ No

d Was an arteriogram carried out? If **Yes**, please state the date of arteriogram: _____ (dd/mm/yyyy)

e (i) Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? If **Yes,** please state the date of surgery: _____ (dd/mm/yyyy)

(ii) Was surgery done via craniotomy? ☐ Yes ☐ No
If No, please state the type of surgery performed:

_____

f Was there surgical shunt insertion from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid? ☐ Yes ☐ No
If **Yes**, please state the date of insertion: _____ (dd/mm/yyyy)

g (i) Was there narrowing of the carotid artery? ☐ Yes ☐ No
If **Yes,** please state the percentage of narrowing : _____ %

(ii) Was Endarterectomy of the carotid artery absolutely necessary? ☐ Yes ☐ No
If **Yes**, please state the actual date where Endarterectomy was performed: _____ (dd/mm/yyyy)

_____ Signature of Attending Doctor

Name & Qualification : _____

_____ Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____



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## SECTION 10 : MAJOR CANCERS

a Please describe the extent of the disease:

(i) What is the histological diagnosis of the disease?

(ii) What is the staging of the Tumour? Please provide full details using appropriate staging classification (eg. TMN classification)

b

| | | | | |
|---|---|---|---|---|
| (i) | Is the disease completely localized? | ☐ Yes | ☐ No | |
| (ii) | Was there invasion of adjacent tissues? | ☐ Yes | ☐ No | |
| (iii) | Were regional lymph nodes involved? | ☐ Yes | ☐ No | |
| (iv) | Were there distant metastases? | ☐ Yes | ☐ No | |

c To be completed ONLY if diagnosis is pre-malignant or non-invasive, skin cancer, prostate cancer, thyroid and bladder cancer or chronic lymphocytic leukaemia:

| | | | |
|---|---|---|---|
| (i) | Is the condition carcinoma-in situ? | ☐ Yes | ☐ No |
| (ii) | Is the condition Cervical Dysplasia CIN 1, CIN 2 or CIN 3 (severe dysplasia without carcinoma-in situ)? | ☐ Yes | ☐ No |
| (iii) | Is the condition Hyperkeratoses, basal cell and squamous skin cancers? | ☐ Yes | ☐ No |
| (iv) | Is the condition melanoma of less than 1.5mm Breslow thickness or less than Clark Level 3? | ☐ Yes | ☐ No |

If **Yes,** please provide full details of size, thickness (Breslow thickness) and depth of invasion (Clark Level):

| | | | |
|---|---|---|---|
| (v) | Is the condition Chronic Lymphocytic Leukaemia classified as lesser than RAI Stage 3? | ☐ Yes | ☐ No |
| (vi) | Is the condition Prostate cancer described as TNM classification T1 (i.e. T1a, T1b, T1c) or equivalent or lesser? | ☐ Yes | ☐ No |
| (vii) | Is the condition Papillary micro-carcinoma of the Thyroid of less than 1cm size in diameter? | ☐ Yes | ☐ No |
| (viii) | Is the condition Papillary micro-carcinoma of the Bladder? | ☐ Yes | ☐ No |
| (ix) | Is the tumour in the presence of HIV infection? | ☐ Yes | ☐ No |

d Please provide details of treatment administered (e.g. surgery, chemotherapy, radiotherapy etc)

e What is the nature of the surgery performed (e.g. mastectomy, prostatectomy, gastrectomy etc)?
Please specify if there was full or partial resection and kindly provide a copy of the operation report to us.

f When was the surgery performed?

(dd/mm/yyyy)

g Has the patient ever suffered from cancer, malignant, pre-malignant or other related conditions or risk factors?
If **Yes**, please provide full details with dates of consultation and the resulting diagnosis:

Signature of Attending Doctor

Name & Qualification :

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) :



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## SECTION 11 : ALZHEIMER'S DISEASE / SEVERE DEMENTIA

a Please describe the extent of the disease:

(i) Is there evidence of deterioration or loss of intellectual capacity? ☐ Yes ☐ No

(ii) Is there abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of patient? ☐ Yes ☐ No

If **Yes,** please describe the behaviour:

_____

(iii) Was there permanent clinical loss of the ability to do the following:

- Remember ☐ Yes ☐ No
- Reason ☐ Yes ☐ No
- Perceive, understand, express and give effect to ideas ☐ Yes ☐ No

b Did the deterioration or loss of intellectual capacity arise from neurosis, psychiatric illnesses or alcohol related brain damage?

If **Yes,** please provide us with the details :

_____

c Was there evidence of cognitive impairment for at least 6 months? If Yes, please state the type of cognitive impairments and its duration:

_____

d Please provide details of any investigations performed including the type of Alzheimer's test (e.g. Mini-mental exam) and its score

_____

e (i) Is the current condition arises from non-organic diseases such as neurosis and psychiatric illnesses? ☐ Yes ☐ No

(ii) Is the current condition a case of drug or alcohol related brain damage ☐ Yes ☐ No

f Was there any memory impairment in the following cognitive areas? ☐ Yes ☐ No

If **Yes**, please tick the box and state the exact date of onset:

Date of Onset

(i) ☐ Aphasia _____ (dd/mm/yyyy)

(ii) ☐ Aproxia _____ (dd/mm/yyyy)

(iii) ☐ Agnosia _____ (dd/mm/yyyy)

(iv) ☐ Disturbance in executive functioning _____ (dd/mm/yyyy)

Please provide the date of last assessment : _____ (dd/mm/yyyy)

g Is the patient currently placed on disease modifying treatment and under your continuous care? ☐ Yes ☐ No

If **Yes,** please provide us with the treatment regime and state the frequency of consultation(s) with your clinic :

_____

_____ Signature of Attending Doctor

Name & Qualification : _____

_____ Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____



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## SECTION 12 : APLASTIC ANAEMIA

a Please provide full details of tests and results which have been performed to establish the diagnosis of Aplastic Anaemia

b What is the cause of patient's aplastic anaemia?

| | | | |
|---|---|---|---|
| (i) | Acute reversible bone marrow failure | ☐ Yes | ☐ No |
| (ii) | Chronic persistent bone marrow failure | ☐ Yes | ☐ No |

c Was any of the following present? If yes, please provide us with the relevant laboratory results.

| | | | |
|---|---|---|---|
| (i) | Anaemia | ☐ Yes | ☐ No |
| (ii) | Neutropenia | ☐ Yes | ☐ No |
| (iii) | Thrombocytopenia | ☐ Yes | ☐ No |

d What is the nature of treatment?

| | | | |
|---|---|---|---|
| (i) | Blood product transfusions | ☐ Yes | ☐ No |
| (ii) | Marrow stimulating agents | ☐ Yes | ☐ No |
| (iii) | Immunosuppressive agents | ☐ Yes | ☐ No |
| (iv) | Bone marrow transplantation | ☐ Yes | ☐ No |

e Is the current condition in any way attributable to HIV infection or AIDS? ☐ Yes ☐ No

If **Yes,** please provide us with the details

## SECTION 13 : BACTERIAL MENINGITIS

a Was the diagnosis confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture? ☐ Yes ☐ No

b Has the patient returned to normal activities? ☐ Yes ☐ No

If **Yes,** please provide the date.

_____
(dd/mm/yyyy)

c What are the patient's present limitations, physical and mental?

d Were there any neurological deficit which has lasted for at least 6 weeks? ☐ Yes ☐ No

Are these neurological deficits likely to be permanent? ☐ Yes ☐ No
If **Yes**, please provide details of the deficits.

e Was the condition present due to HIV / AIDS infections? ☐ Yes ☐ No

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## SECTION 14 : BENIGN BRAIN TUMOUR

a Has the tumour caused an increase in the intracranial pressure? ☐ Yes ☐ No

If **Yes**, please provide the detailed location of the tumour.

b Is the tumour life threatening? ☐ Yes ☐ No

c Has the tumour caused damage to the brain? ☐ Yes ☐ No
If yes, please provide details.

d Has the patient undergone surgical removal? ☐ Yes ☐ No
If **Yes**, please state the type and exact date the surgery was perform

(i) ☐ Transphenoidal

_____ (dd/mm/yyyy)

(ii) ☐ Transnasal Hypophysectomy

_____ (dd/mm/yyyy)

(iii) ☐ Open craniotomy

_____ (dd/mm/yyyy)

e If the surgical removal is not performed, has the tumour caused permanent neurological deficit? ☐ Yes ☐ No
If **Yes**, please provide details of the deficits.

f Is the patient's condition a cyst, granuloma, vascular malformation or haematoma? ☐ Yes ☐ No

g Is the patient's tumour in the pituitary gland or spinal cord? ☐ Yes ☐ No

h Is the tumour confirmed by imaging studies such as CT scan or MRI? ☐ Yes ☐ No

## SECTION 15 : BLINDNESS (LOSS OF SIGHT)

a What was the date of onset?

_____ (dd/mm/yyyy)

b What is the current visual acuity of both eyes, using the Snellen eye chart?

Left eye: _____ Right eye: _____

c What forms of treatment were rendered?

d Is the current blindness in both eyes permanent and irreversible? ☐ Yes ☐ No

e Will further surgery improve his / her sight? ☐ Yes ☐ No
If **Yes**, what kind of surgery will be necessary and what is the tentative date of surgery?

f Is the condition resulting from alcohol or drug misuse? ☐ Yes ☐ No
If **Yes,** please provide us with the details.

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## SECTION 16 : COMA

a What was the date of onset?

_____ (dd/mm/yyyy)

b How was the diagnosis established? Please include a copy of diagnostic investigation reports (eg electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) etc)

c Was there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for:

(i) at least 48 hours? ☐ Yes ☐ No

(ii) at least 72 hours? ☐ Yes ☐ No

(iii) at least 96 hours? ☐ Yes ☐ No

d Was there brain damage resulting in permanent neurological deficit? ☐ Yes ☐ No

e Has the sequelae lasted more than 30 days from the onset of the coma? ☐ Yes ☐ No

f Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug-serum level testing? ☐ Yes ☐ No

If **Yes,** what is the frequency of attack per week?

_____ attacks per week

g Is the patient taking prescribed anti-epileptic (anti-convulsant) medications? ☐ Yes ☐ No

If **Yes**, please state the type(s) of medication and period he has been on such medication:

h Would you consider the patient to be on optimal drug therapy? ☐ Yes ☐ No

If **Yes,** please state the type(s) and recommended duration of such therapy:

i Is the condition resulting from alcohol, drug misuse or medically induced coma? ☐ Yes ☐ No

If **Yes,** please provide us with the details.

## SECTION 17 : DEAFNESS (LOSS OF HEARING)

a What was the date of onset?

_____ (dd/mm/yyyy)

b Was the diagnosis confirmed by an audiometric and sound-threshold? ☐ Yes ☐ No

c Is the loss of hearing considered irreversible? ☐ Yes ☐ No

d Is there a loss in all frequencies of hearing of:

(i) at least 60 decibels ☐ Yes ☐ No

(ii) at least 80 decibles ☐ Yes ☐ No

e Has the patient undergone surgery to:

(i) drain cavernous sinus thrombosis ☐ Yes ☐ No

(ii) insert implant due to permanent damage of cochlea or auditory nerve ☐ Yes ☐ No

If **Yes**, please state the actual date of surgery:

_____ (dd/mm/yyyy)

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## SECTION 18 : VIRAL ENCEPHALITIS

a Was the condition caused by viral infection? ☐ Yes ☐ No

b Was the patient hospitalised? ☐ Yes ☐ No
If **Yes,** please provide the exact dates and duration of admission:

c Has the patient returned to normal activities? ☐ Yes ☐ No
If **Yes,** please provide the date.

_____ (dd/mm/yyyy)

d What are the patient's present limitations, physical and mental?

e Was there any significant and serious permanent neurological deficit? ☐ Yes ☐ No
If **Yes**, please provide details of the deficit.

f Are the permanent neurological deficits documented for at least 6 weeks? ☐ Yes ☐ No
If **Yes,** please provide details.

g Was the condition present due to HIV / AIDS infections? ☐ Yes ☐ No

## SECTION 19 : END STAGE LIVER DISEASE

a Was there end stage liver failure? ☐ Yes ☐ No
If **Yes,** please state the date of diagnosis

_____ (dd/mm/yyyy)

b Was there evidence of permanent jaundice? ☐ Yes ☐ No

c Was there evidence of ascites? ☐ Yes ☐ No

d Was there evidence of hepatic encephalopathy? ☐ Yes ☐ No

e Was there partial hepatectomy of at least one entire lobe of the liver? ☐ Yes ☐ No
If **Yes,** please state the exact date of surgery

_____ (dd/mm/yyyy)

f Was there cirrhosis of the liver? ☐ Yes ☐ No
If **Yes,** please provide us with the HAI-Knodell Scores together with the liver biopsy result

g. What was the cause of the liver failure?

h Was the liver disease secondary to alcohol or drug abuse? ☐ Yes ☐ No
If **Yes**, please provide details:

i What is the current condition of the patient and the prognosis?

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## SECTION 20 : END STAGE LUNG DISEASE

a (i) Has the patient's lung disease reached end-stage? ☐ Yes ☐ No
If yes, please state the exact date:

_____ (dd/mm/yyyy)

(ii) What is the FEV1 test result of the patient?

_____

(iii) Is the patient undergoing extensive and permanent oxygen therapy for hypoxemia? ☐ Yes ☐ No

(iv) What is the Arterial blood gas analyses ($PaO_2$) of the patient?

_____

b (i) Is there evidence of acute attack of severe asthma with persistent status of asthmaticus? ☐ Yes ☐ No
If yes, please state the exact date and details:

_____ (dd/mm/yyyy)

(ii) Was the patient hospitalised and required assisted ventilation with a mechanical ventilator for a continuous period of at least 4 hours? ☐ Yes ☐ No
If **Yes**, please explain:

_____

c Please provide us with the first and subsequent dates where the patient consulted you for pulmonary emboli:

| Date | Sign and symptoms | Treatment Provided | Patient's response to treatment | Name and Address of Attending Doctor |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

d Has the patient undergone surgery to:
(i) Insert vena cava filter due to documented proof of recurrent pulmonary emboli ☐ Yes ☐ No
(ii) Completely remover of one lung as a result of an accident or an illness ☐ Yes ☐ No
If **Yes**, please state the actual date of surgery:

_____ (dd/mm/yyyy)

## SECTION 21 : TERMINAL ILLNESS

a What is the diagnosis and prognosis of patient's illness?

_____

b In your opinion, is the condition highly likely to lead to death within 12 months? ☐ Yes ☐ No
If **Yes**, please provide your basis.

_____

c Is the condition present as a result of HIV / AIDS? ☐ Yes ☐ No

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## SECTION 22 : FULMINANT HEPATITIS

| | | | | |
|---|---|---|---|---|
| a | (i) | Please provide full and exact details of the diagnosis including the viru(s) involved. | | |
| | (ii) | What is the approximate date of onset? (dd/mm/yyyy) | | |
| | (iii) | Is there a rapidly decreasing liver size? | ☐ Yes | ☐ No |
| | (iv) | Is there a submassive to massive necrosis of the liver? | ☐ Yes | ☐ No |
| | (v) | Is there a rapidly deterioration of liver function? | ☐ Yes | ☐ No |
| | (vi) | Is there deepening jaundice? | ☐ Yes | ☐ No |
| | (vii) | is there hepatic encephalopathy? | ☐ Yes | ☐ No |
| b | (i) | Has the patient undergone biliary tract reconstruction surgery involving choledochoenterostomy (choledochojejunostomy or choledochoduodenostomy) for the treatment of biliary tract disease, including biliary atresia?<br>If **Yes**, please state the actual date of surgery: (dd/mm/yyyy) | ☐ Yes | ☐ No |
| | (ii) | Is the biliary tract disease NOT amendable by other surgical or endoscopic measures? | ☐ Yes | ☐ No |
| | (iii) | Is the procedure considered the most appropriate treatment? | ☐ Yes | ☐ No |
| | (iv) | Is patient's current condition a consequence of gall stone disease or cholangitis? | ☐ Yes | ☐ No |
| c | (i) | Is patient's condition of chronic primary sclerosing cholangitis confirmed by cholangiogram? | ☐ Yes | ☐ No |
| | (ii) | Is there progressive obliteration of the bile ducts? | ☐ Yes | ☐ No |
| | (iii) | Is there permanent jaundice? | ☐ Yes | ☐ No |
| | (iv) | Is there a need for immunosuppressive treatment, drug therapy for intractable pruritis or ballon dilation or stenting of the bile ducts?<br>If **Yes**, please provide the details: | ☐ Yes | ☐ No |
| | (v) | Is patient's current condition a consequence of biliary surgery, gall stone disease, infection, inflammatory bowel disease or other secondary precipitants?<br>If **Yes**, please provide the details: | ☐ Yes | ☐ No |
| d | | What is the current condition of the patient and what is the prognosis? | | |

Signature of Attending Doctor

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## SECTION 23 : HIV DUE TO BLOOD TRANSFUSION & OCCUPATIONALLY ACQUIRED

a (i) Was the infection due to :

- blood transfusion? ☐ Yes ☐ No
- organ transplant? ☐ Yes ☐ No
- physical or sexual assault? ☐ Yes ☐ No

(ii) Was the blood transfusion or organ transplant medically necessary or given as part of medical treatment? ☐ Yes ☐ No

(iii) Did the incident of infection occur in Singapore? ☐ Yes ☐ No

If **Yes**, please provide the exact date and details:

_____ _____ (dd/mm/yyyy)

(iv) Was the infection resulted from any other means including sexual activity and the use of intravenous drugs? If **Yes**, please state the likely cause: ☐ Yes ☐ No

_____

(v) Was the incident of infection established to involve a definite source of the HIV infected fluids? ☐ Yes ☐ No

(vi) Was the incident of infection reported to the appropriate authority? ☐ Yes ☐ No

(vii) Is the Institution where the blood transfusion or organ transplant was performed able to trace the origin of the HIV tainted blood? ☐ Yes ☐ No

b. Is the patient suffering from Thalassaemia Major or Haemophilia? ☐ Yes ☐ No

c. Is the occupation of the patient a medical practitioner, houseman, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in Singapore? ☐ Yes ☐ No
If **Yes,** please state the actual occupation and name of employer or Institution:

_____

d (i) Was there an accident whilst the patient was carrying out the normal professional duties of his occupation in Singapore? ☐ Yes ☐ No
If **Yes,** please state the date of accident:

_____ (dd/mm/yyyy)

(ii) Was the accident involved a definite source of the HIV infected fluids? ☐ Yes ☐ No

e (i) Was an HIV antibody test done before the incident of infection? ☐ Yes ☐ No

If **Yes,** what was the result?

_____

(ii) Was an HIV antibody test done after the incident of infection? ☐ Yes ☐ No

If **Yes,** what was the result?

_____

_____ _____

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## SECTION 24 : KIDNEY FAILURE

| | | | | |
|---|---|---|---|---|
| a | (i) | Has the patient's renal disease reached end-stage? | ☐ Yes | ☐ No |
| | (ii) | Is there chronic renal failure of both kidneys? | ☐ Yes | ☐ No |
| | (iii) | Is the renal failure reversible? | ☐ Yes | ☐ No |
| b | (i) | Is the patient undergoing regular peritoneal dialysis or haemodialysis? | ☐ Yes | ☐ No |
| | | If **Yes,** what was the date of commencement? _____ (dd/mm/yyyy) | | |
| | (ii) | Has renal transplantation been performed? | ☐ Yes | ☐ No |
| | | If **Yes**, when was it done? _____ (dd/mm/yyyy) | | |
| c | (i) | Was the patient a recipient of the renal transplant? | ☐ Yes | ☐ No |
| | (ii) | Is the renal dialysis / transplantation required as a life-saving procedure? | ☐ Yes | ☐ No |
| | (iii) | Was there decreased renal function of at least eGFR less than 15ml/min/1.73m2 body surface? | ☐ Yes | ☐ No |
| | | If **Yes**, did it persist for a period of at least 6 months and what are the details: | | |

## SECTION 25 : LOSS OF SPEECH

| | | | | |
|---|---|---|---|---|
| a | (i) | What is the date of onset? _____ (dd/mm/yyyy) | | |
| | (ii) | Is the loss of speech considered total and irrecoverable? | ☐ Yes | ☐ No |
| | (iii) | Has the inability to speak established for a continuous period of 12 months? | ☐ Yes | ☐ No |
| | (iv) | Were there any associated neurological or psychiatric conditions contributing to the patient's loss of speech? If **Yes,** please provide details. | ☐ Yes | ☐ No |
| b | | What was the cause of the loss of speech? | | |
| c | (i) | Has tracheostomy been performed? | ☐ Yes | ☐ No |
| | | If **Yes**, what is purpose of such treatment and when was it done? _____ (dd/mm/yyyy) | | |
| | (ii) | Was tracheostomy performed for treatment of lung or airway disease or as a ventilator support measure following major trauma or burns? | ☐ Yes | ☐ No |
| | | If **Yes**, please provide the details: | | |
| | (iii) | Was the patient under the care of medical specialist in a designated intensive care unit (ICU)? | ☐ Yes | ☐ No |
| | | If **Yes**, how many days was he/she warded in ICU: | | |
| | (iv) | Is the tracheostomy required to remain in place and functional for a period of at least 3 months? | ☐ Yes | ☐ No |

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## SECTION 26 : MAJOR BURNS

a (i) What is the date of onset?

_____ (dd/mm/yyyy)

(ii) Please state the areas affected, the percentage of surface area and the degree of burns in each affected area:

| Area Affected | Percentage of surface area | Degree of burns |
|---|---|---|
| | | |
| | | |

(iii) Were there Second Degree (partial thickness of the skin) burns covering at least 20% of the surface of the patient's body? ☐ Yes ☐ No

(iv) Were there Third Degree (full thickness of the skin) burns covering at least 20% of the surface of the patient's body? ☐ Yes ☐ No

(v) Were there Third Degree (full thickness of the skin) burns covering at least 50% of patient's face or head? ☐ Yes ☐ No

b (i) Where and how did the accident happen resulting in the major burns?

_____

(ii) Are the burns self-inflicted? ☐ Yes ☐ No
If **Yes**, please provide details.

_____

c (i) Is surgical debridement under general anaesthetic required? ☐ Yes ☐ No
If **Yes**, when will it be performed?

_____ (dd/mm/yyyy)

(ii) Is skin grafting required? ☐ Yes ☐ No
If **Yes**, when will it be performed?

_____ (dd/mm/yyyy)

## SECTION 27 : MAJOR ORGAN / BONE MARROW TRANSPLANT

a (i) Which of the organ is involved? _____

(ii) What is the exact date of transplant?

_____ (dd/mm/yyyy)

(iii) What is the prognosis?

_____

(iv) Was the transplant resulted from an irreversible end stage failure of the relevant organ? ☐ Yes ☐ No

b (i) For bone marrow transplant, is the receipt of transplant from human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation? ☐ Yes ☐ No

(ii) For small bowel transplant, is there receipt of at least one meter of small bowel resulting from intestinal failure? ☐ Yes ☐ No

(iii) For corneal transplant, is there receipt of a whole cornea due to irreversible scarring with resulting reduced visual acuity which cannot be corrected with other methods? ☐ Yes ☐ No

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## SECTION 28 : MOTOR NEURONE DISEASE

a (i) Is there progressive degeneration of:

- corticospinal tracts; ☐ Yes ☐ No
- anterior horn cells; ☐ Yes ☐ No
- bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis ☐ Yes ☐ No

If answer to any of the above is **Yes,** please provide details:

_____

(ii) Please provide details of the extent of neurological deficits.

_____

(iii) Are the neurological deficits likely to be permanent? ☐ Yes ☐ No

b (i) For peripheral neuropathy, is it arising from anterior horn cells resulting in significant motor weakness, fasciculation and muscle wasting? ☐ Yes ☐ No

(ii) Is the diagnosis evident in nerve conduction studies? ☐ Yes ☐ No

(iii) Is there a permanent need for the use of walking aids or wheelchair? ☐ Yes ☐ No

c (i) Is the current condition arising from diabetic neuropathy? ☐ Yes ☐ No

(ii) Is the neuropathy arising from excessive alcohol consumption? ☐ Yes ☐ No

## SECTION 29 : MULTIPLE SCLEROSIS

a i. Is there a history of repeated relapse and remission or a steady progressive disability? ☐ Yes ☐ No

ii. Are there lesions producing well-defined neurological deficits involving the optic nerves, brain stem and spinal cord which occurred over a continuous period of :

- at least 3 months? ☐ Yes ☐ No
- at least 6 months? ☐ Yes ☐ No

iii. Are there signs and symptoms of multiple lesions? ☐ Yes ☐ No

iv. Was the neurological damages caused by SLE or HIV / AIDS? ☐ Yes ☐ No
If **Yes,** what was the cause?

_____

b Is there a well documented history of exacerbations and remissions of neurological signs? ☐ Yes ☐ No

If **Yes,** please provide the details, including dates of each episode:

_____

c Has the patient returned to normal activities? ☐ Yes ☐ No

If **Yes,** please provide the date.

_____
(dd/mm/yyyy)

d What are the patient's present limitations, physical and mental?

_____

_____ _____

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## SECTION 30 : MUSCULAR DYSTROPHY

a (i) Is there any evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex? If **Yes,** please describe the findings: ☐ Yes ☐ No

(ii) Which are the muscles involved?

b (i) Was the diagnosis confirmed by an electromyogram? ☐ Yes ☐ No

(ii) Was the diagnosis confirmed by muscle biopsy? ☐ Yes ☐ No

c Is the patient able to perform (whether aided or unaided) for a continuous period of at least 6 months the followings:

(i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means ☐ Yes ☐ No

(ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances ☐ Yes ☐ No

(iii) Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No

(iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene ☐ Yes ☐ No

(v) Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

(vi) Ability to feed oneself once food has been prepared and made available ☐ Yes ☐ No

d (i) For bowel and bladder dysfunction, is there permanent dysfunction requiring permanent regular self catheterisation or permanent urinary conduit? ☐ Yes ☐ No

(ii) Has the bowel and bladder dysfunction lasted for at least 6 months? ☐ Yes ☐ No

If **Yes,** please provide the exact date of onset:

_____
(dd/mm/yyyy)

## SECTION 31 : PARALYSIS (LOSS OF USE OF LIMBS)

a i. When was the date of onset?

_____
(dd/mm/yyyy)

ii. Please state the number and limbs involved?

b Is there total and irreversible loss of use of at least 1 entire limb? ☐ Yes ☐ No

c Was the paralysis or loss of use of limbs due to illness or injury? ☐ Yes ☐ No
Please provide details on the cause:

d Was the paralysis or loss of use of limbs caused by self-inflicted injuries? ☐ Yes ☐ No
If **Yes**, please provide details:

Signature of Attending Doctor

Name & Qualification : _____

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## SECTION 32 : PARKINSON'S DISEASE

a (i) What is the cause of the disease?

b (i) Can the condition be controlled with medication? ☐ Yes ☐ No

(ii) If **Yes**, please provide details and exact date where medication was commenced:

(iii) Are there signs of progressive impairment? ☐ Yes ☐ No
If **Yes,** please provide details:

(iv) Did Parkinson's Disease result from treatment for any other illness, or is it associated with any other disease e.g. Wilson's Disease or Huntington's Chorea? ☐ Yes ☐ No
If **Yes,** please provide details:

c Is the patient able to perform (whether aided or unaided) for a continuous period of at least 6 months the followings:

(i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means ☐ Yes ☐ No

(ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances ☐ Yes ☐ No

(iii) Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No

(iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene ☐ Yes ☐ No

(v) Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

(vi) Ability to feed oneself once food has been prepared and made available ☐ Yes ☐ No

d (i) Is the Parkinsonism due to: ☐ Yes ☐ No
- drug induced cause
- toxic cause ☐ Yes ☐ No

## SECTION 33 : POLIOMYELITIS

a i. What was the cause of the disease?

ii. What is the current condition of the patient and what is the prognosis?

iii. Was there paralysis of the limb muscles or respiratory muscles for at least 3 months? ☐ Yes ☐ No

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## SECTION 34 : PRIMARY PULMONARY HYPERTENSION

| | | | |
|---|---|---|---|
| a | (i) | Was there a dyspnoea and fatigue? | ☐ Yes ☐ No |
| | (ii) | Is the pulmonary hypertension due to primary cause? | ☐ Yes ☐ No |
| | (iii) | Is the pulmonary hypertension due to secondary cause? | ☐ Yes ☐ No |
| | (iv) | Is there presence of right ventricular hypertrophy, dilation and signs of right heart failure and decompensation? | ☐ Yes ☐ No |
| | (v) | Was cardiac catherterization carried out to establish the pulmonary hypertension? | ☐ Yes ☐ No |
| b | | Was the patient able to engage in any physical activity without discomfort? | ☐ Yes ☐ No |
| c | | Are the symptoms present even at rest? | ☐ Yes ☐ No |
| d | | Was there permanent physical impairment which fulfills the the NYHA classification of cardiac impairment? | ☐ Yes ☐ No |
| | | If **Yes**, please state the class of impairment: | NYHA Class : I / II / III / IV |

## SECTION 35 : SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS

| | | | |
|---|---|---|---|
| a | (i) | Does patient's current condition requires systemic immunosuppressive therapy due to involvement of multiple organ? | ☐ Yes ☐ No |
| | | If **Yes**, please state the exact commencement date of the therapy : _____ (dd/mm/yyyy) | |
| | (ii) | Are the following internal organs involved: | |
| | | ▪ kidneys | ☐ Yes ☐ No |
| | | ▪ brain | ☐ Yes ☐ No |
| | | ▪ heart or pericardium | ☐ Yes ☐ No |
| | | ▪ lungs or pleura | ☐ Yes ☐ No |
| | | ▪ joints in the presence of polyarticular inflammatory arthritis | ☐ Yes ☐ No |
| b | (i) | Was renal biopsy performed: | ☐ Yes ☐ No |
| | | If **Yes**, please state the exact date biopsy was done : _____ (dd/mm/yyyy) | |
| | (ii) | Are both kidneys involved : | ☐ Yes ☐ No |
| | | If **Yes**, please state the class of Lupus Nephritis in accordance with WHO classification : | Lupus Nephritis Class : I / II / III / IV |
| c | (i) | Were there discoid lupus and or those forms with haematological involvement? If Yes, please provide details: | ☐ Yes ☐ No |

_____

_____

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## SECTION 36 : MAJOR HEAD TRAUMA

a (i) What is the date of accident?

_____
(dd/mm/yyyy)

b (i) Where and how did the accident happen resulting in the major head trauma?

_____

(ii) Did the injury result from a self-inflicted act? ☐ Yes ☐ No
If **Yes**, please provide details.

(iii) Was there reason to suspect that there were contributory circumstances which led to the injury, e.g. under the influence of alcohol, drugs, etc? ☐ Yes ☐ No
If **Yes**, please provide details.

(iv) Was there a police report made with regard to this accident? ☐ Yes ☐ No
If **Yes**, please provide a copy of the police report (if available).

c (i) Was there any form of neurological deficit still present 6 weeks after the date of accident? ☐ Yes ☐ No
If **Yes**, please state the neurological deficit(s).

(ii) Is this neurological deficit likely to be permanent? ☐ Yes ☐ No
If **No**, please state the date of recovery or date which the patient is expected to recover from the neurological deficit.

_____
(dd/mm/yyyy)

d (i) Did the patient undergo open craniotomy for treatment of depressed skull fracture or major intracranial injury? ☐ Yes ☐ No
If **Yes**, please provide details and attach a copy of the surgery note.

(ii) If the patient had suffered from facial injury, was there any re-constructive surgery above the neck to correct disfigurement (restoration or re-constructive of the shape and appearance of facial structures which are defective, missing or damaged or misshapened)? ☐ Yes ☐ No
If **Yes**, please provide details of the surgery performed.

e (i) Is the patient mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? ☐ Yes ☐ No

f To be completed ONLY if the patient had accidental cervical spinal cord injury:

(i) Has the accidental cervical spinal cord injury resulted in the loss of use of at least one entire limb for at least 6 weeks from the accident? ☐ Yes ☐ No
If **Yes**, please provide details.

_____

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TOKIO MARINE
INSURANCE GROUP

# AUTHORIZATION FORM FOR MEDICAL REPORT

NAME OF PATIENT : _____

NRIC NO. : _____ POLICY NO. : _____

This consent form is required for an insurance claim.

**Authorization**

I / We hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd. ("Company"), any relevant information concerning the above-named patient, and;

(b) the Company release to any medical source, insurance office, or organization, any relevant information concerning the above-named patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

_____

Signature of *Patient / Patient's Parent / Guardian

Name : _____

Address : _____

_____

NRIC No. : _____ Relationship to patient : _____

* If the patient is below 21 years old, this form should be signed by the patient's parent / guardian



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