Manulife

ATTENDING PHYSICIAN'S STATEMENT (MAJOR PLASTIC SURGERY DUE TO ACCIDENTS)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician at Insured's expense.

1. PATIENT'S PARTICULARS

Name of the Patient: _____ NRIC/Passport No: _____

Date of Birth: _____ Sex: _____ Admission No: _____ Ward No: _____

Date of Admission: _____ Date of Discharge: _____

2. DETAILS OF PATIENT'S CONDITION

In order for a claim under this policy to be paid, the following definition must be satisfied:

Major plastic surgery due to accidents means the undergoing of re-constructive surgery (restoration or re-construction of the shape of and appearance of body structures which are defective, missing or damaged or misshapen) performed by a registered surgeon to correct body disfigurement caused by an Accident or Assault.

(a) Please describe the exact details of the patient's condition.

_____

_____

_____

(b) Date when you first consulted for the condition: _____/ _____/ _____
dd mm yyyy

(c) Date of accident: _____/ _____/ _____
dd mm yyyy

(d) Where did the accident occur?

_____

_____

(e) Please provide a brief description of the accident.

_____

_____

_____

_____

(f) Please give details of the circumstances leading to the injury.

_____

_____

_____

Manulife (Singapore) Pte Ltd.
Reg. No. 198002116D
Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424
Tel: 67371221 Website: www.manulife.com.sg

(g) Was the patient under the influence of alcohol at the time of accident? □ Yes □ No

If yes, please state the blood alcohol content: _____

(h) In your opinion, were the injuries the result of the accident described above? □ Yes □ No

If yes, please state your reasons.

_____

(i) Was there reason to suspect that there were contributory circumstances which led to the injury?

□ Yes □ No

If yes, please state your reasons.

_____

_____

(j) Was surgery required for this condition? □ Yes □ No

(k) If yes, type of surgery performed: _____

(l) Please state the reason(s) for surgery.

_____

_____

_____

_____

(m) Please describe the part(s) of the body structures affected by surgery.

_____

_____

_____

_____

(n) Date of surgery: _____/ _____/ _____
dd mm yyyy

(o) Name and address of Hospital: _____

_____

(p) Name and address of the Doctor who performed the surgery.

_____

_____

(q) Please give full details of all investigations performed in relation to this condition and their results.

_____

_____

_____

(r) Please give details of the patient's history and present habits pertaining to alcohol consumption, cigarette smoking and drug addiction.

_____

_____

_____

_____

3. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

(i) Name of referral doctor: _____

(ii) Name of clinic/ hospital: _____

(iii) Date referred: _____

(b) Did the patient consult other doctors for this condition before she consulted you? □ Yes □ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom she consulted.

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

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

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

(d) Please provide us with any other additional information that will enable the Company to assess this 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.

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp

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