CRISIS COVER CLAIM FORM

OTHER CRITICAL ILLNESS & MEDICAL CONDITION

Important Notes

1. Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.
2. The issue of this form is in no way an admission of liability. No claim can be considered unless the medical specialist report section is furnished at the expense of the claimant.
3. The Company reserves the rights to request for additional documents when deemed necessary.

PART I

(To be completed by the Life Assured who is at least 18 years old or the Policyowner if the Life Assured is below 18 years old)

DETAILS OF POLICY

Policy Number(s) the benefit(s) you would like to claim:

DETAILS OF LIFE ASSURED

Full Name					
NRIC / Passport No.		Date of birth		Gender	
Address					
Contact No.			Email address		
Occupation			Name and address of Employer		

TYPE OF CLAIM

1. Please tick [√] in the appropriate box for the respective category of benefit and to state the type of illness / medical conditions you are claiming on the above policy(ies).

☐ **Critical Illness**	☐ **Early / Intermediate/ Pre-critical Medical Conditions**

DETAILS OF ILLNESS / MEDICAL CONDITION

2. Describe fully the signs or symptoms for which Life Assured has consulted doctor or received treatment.

C170621

3. Date when signs or symptoms first started		DD		MM		YY
4. Date when Life Assured first consulted a doctor for the above signs or symptoms.		DD		MM		YY

5. Please provide the following details accordingly if the consultation was due to illness or accident.

If consultation was for illness, describe fully the nature and extent of illness in terms of its diagnosis and treatment received.	If consultation was due to accident, describe fully the date of accident, how and where did the accident occur.		
	Was the accident reported to the police?	Yes	No
	If yes, please provide: • the name of police officer and police station at which the accident was reported; and • a copy of the police report.		

6. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury?	Yes	No
If yes, please give details.		

7. Please provide the details of all doctors or specialists whom Life Assured has consulted in connection with his/her illness/injury:-

Name of Doctor	Name and Address of Clinic / Hospital	Dates of consultation	Reason(s) for consultation

8. Please provide the details of Life Assured's regular doctor and company doctor whom he/she has consulted for minor ailments (e.g. flu, cough, fever), high blood pressure, high cholesterol, diabetes etc.:-

Name of Doctor	Name and Address of Clinic / Hospital	Dates of consultation	Reason(s) for consultation

OTHER INSURANCE

9. Does Life Assured have similar benefits with any other company? If yes, please give full details :-

Name of Insurer	Type of Plan	Date of Issue	Sum Assured

PAYMENT METHOD FOR CLAIM SETTLEMENT

10. Please tick one of the boxes below to indicate your preferred payment method.

☐ Cheque to be mailed directly to Policyowner address

☐ Cheque to be collected by Prudential Financial Consultant

☐ Cheque to be mailed directly to Prudential Financial Consultant at Agency

Name and Contact No. of your appointed Prudential Financial Consultant:

☐ Direct credit of proceeds into Policyowner's SGD dollar bank account
(*if you select this payment mode, you need to* ***submit*** *a copy of the bank book or bank statement stating account holder name and number*)

Name of Bank	Branch of Bank	Bank Account Number	Name of Account Holder

Name of Life Assured: NRIC / Passport No. of Life Assured:

DECLARATION

1. I understand and agree that the submission of this form does not mean that my request will be processed. I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.

2. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I further acknowledge and accept that Prudential Assurance Company Singapore (Pte) Limited ("**PACS**") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.

3. I hereby warrant and represent that I have been properly authorised by the policyholder and the applicable insured(s) to submit information pertaining to such insured's claims.

4. I acknowledge and accept that the furnishing of this form, or any other forms supplemental thereto, by PACS, is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights and defenses.

5. I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary.

6. I confirm that I have paid in full all the bill(s)/invoice(s)/receipt(s) that I have submitted to PACS for reimbursement and have not claimed and do not intend to claim from other company(ies)/person(s).

7. I agree to produce all original bill(s)/invoice(s)/receipt(s) that were submitted for reimbursement to PACS for verification as it deems necessary.

8. For the purposes of (i) assessing, processing and/or investigating my claim(s) arising under the Policy or any of my other polic(ies) of insurance with PACS and such other purposes ancillary or related to the assessing, processing and/or investigating of such claim(s); (ii) administering the Policy, (iii) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to PACS whether in relation to the Policy or any of my other polic(ies) of insurance with PACS, (iv) storage and retention, (v) meeting requirements of prevailing internal policies of PACS, and/or (vi) as set out in PACS Privacy Notice ("**Purpose**"), I authorise, agree and consent to:

   a. Any person(s) or organisation(s) that has relevant information concerning the policyowner and the insured person(s) (including any medical practitioner, medical/healthcare provider, financial service providers, insurance offices, government authorities/regulators, statutory boards, employer, or investigative agencies) ("**Person(s)/Organisation(s)**"), to disclose, release, transfer and exchange any information with PACS and its related corporations, respective representatives, agents, third party service providers, contractors and/or appointed distribution/business partners (collectively referred to as "**Prudential**"), including without limitation, personal data, medical information, medical history, employment and financial information, including the taking of copies of such records; and

   b. Prudential collecting, using, disclosing, releasing, transferring and exchanging personal data about me, the policyowner and the insured person(s), with the Person(s)/Organisation(s), PACS's related group of companies, third party service providers, insurers, reinsurers, suppliers, intermediaries, lawyers/law firms, other financial institutions, law enforcement authorities, dispute resolution centres, debt collection agencies, loss adjustors or other third parties for the Purpose.

9. Where any personal data ("**3rd Party Personal Data**") relating to another person ("**Individual**") (including without limitation, insured persons, family members, and beneficiaries) is disclosed by me or permitted by me to be disclosed in accordance with Clause 8 above, I represent and warrant that I have obtained the consent of the Individual for Prudential to collect and use the 3rd Party Personal Data and to disclose the 3rd Party Personal Data to the persons enumerated above, whether in Singapore or elsewhere, for the Purpose stated above and in PACS Privacy Notice.

10. I understand that I can refer to PACS Privacy Notice, which is available at https://www.prudential.com.sg/Privacy-Notice for more information on contacting PACS for Feedback, Access, Correction and Withdrawal of using my/our personal data.

    I understand that if I am an European Union ("EU") resident individual (i.e. my residential address is based in any of the EU countries), I can refer to PACS Privacy Notice for more information on the rights available to me under the GDPR.

11. I agree to indemnify Prudential for all losses and damages that Prudential may suffer in the event that I am in breach of any representation and warranty provided to me herein.

12. I agree to receive communication on the claim by email, SMS and/or hard copies by post.

13. I agree that this (i) Prudential shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.

Date and signature of Life Assured (Policyowner to sign if Life Assured is below age 18 years)	Date and signature of Policyowner

Name of Patient: NRIC / Passport No. of Patient:

PART II - MEDICAL SPECIALIST REPORT

CRITICAL ILLNESS, EARLY & INTERMEDIATE STAGE MEDICAL CONDITIONS

(To be completed by the Life Assured's attending medical specialist)

Please circle the appropriate illness/disease/condition in the table and complete the relevant sections in respect to the illness/disease/condition claims. **Please submit ONLY the relevant sections to us upon completion.**

	Critical Illness	Early / Intermediate / Pre-critical medical conditions		Sections to be completed
1	Alzheimer's Disease / Severe Dementia	Moderately Severe Alzheimer's Disease or Dementia	-	1, 2, 30, 31
2	Persistent Vegetative State (Apallic Syndrome)	Akinetic Mutism	Locked in syndrome	1, 3, 30, 31
3	Irreversible Aplastic Anaemia	Reversible Aplastic Anaemia	Myelodysplastic Syndrome or Myelofibrosis	1, 4, 30, 31
4	Severe Bacterial Meningitis	Bacterial Meningitis with full recovery	Bacterial meningitis with reversible neurological deficit	1, 5, 30, 31
5	Blindness (Irreversible Loss of Sight)	Loss of sight in one eye	Optic Nerve Atrophy with low vision	1, 6, 30, 31
6	Coma	Coma for 48 hours	Severe Epilepsy or Coma for 72 hours	1, 7, 30, 31
7	Deafness (Irreversible Loss of Hearing)	Partial loss of hearing or Cavernous sinus thrombosis surgery	Cochlear implant surgery	1, 8, 30, 31
8	End Stage Liver Failure	Liver surgery	Liver Cirrhosis	1, 9, 30, 31
9	End Stage Lung Disease	Severe Asthma or Insertion of a Veno-cava filter	Surgical removal of one lung	1, 10, 30, 31
10	Fulminant Hepatitis	Hepatitis with Cirrhosis or Biliary Tract reconstruction surgery	Chronic Primary Sclerosing Cholangitis	1, 11, 30, 31
11	Open Chest Heart Valve Surgery	Percutaneous Valve Surgery	Percutaneous value replacement or device repair	1, 12, 30, 31
12	HIV Due to Blood Transfusion and Occupationally Acquired HIV	HIV due to Assault, Organ Transplant or Occupationally Acquired HIV	-	1, 13, 30, 31
13	Loss of Independent Existence	Loss of independent existence (early stage)	Loss of independent existence (intermediate stage)	1, 14, 30, 31
14	Irreversible Loss of Speech	Loss of Speech due to neurological disease or neurological injury or Permanent or Temporary Tracheostomy	Loss of speech due to vocal cord paralysis	1, 15, 30, 31
15	Major Burns	Mild severe burns	Moderately severe burns	1, 16, 30, 31
16	Major Head Trauma	Facial reconstructive surgery or Spinal cord injury	Intermediate stage Major Head Trauma	1, 17, 30, 31
17	Major Organ / Bone Marrow Transplantation	Small bowel transplant or Corneal transplant	Major organ/ bone marrow transplant (on waitlist)	1, 18, 30, 31
18	Motor Neurone Disease	Early Motor Neurone Disease or Peripheral Neuropathy	-	1, 19, 30, 31
19	Multiple Sclerosis	Early Multiple Sclerosis	Mild Multiple Sclerosis	1, 20, 30, 31
20	Muscular Dystrophy	Moderately severe Muscular Dystrophy or Spinal Cord Disease or Injury resulting in Bowel and Bladder Dysfunction	-	1, 21, 30, 31
21	Paralysis (Irreversible Loss of Use of Limbs)	Loss of Use of One Limb	Loss of Use of One Limb requiring Prosthesis	1, 22, 30, 31
22	Idiopathic Parkinson's Disease	Early and moderately severe Parkinson's Disease	-	1, 23, 30, 31
23	Poliomyelitis	Peripheral neuropathy	Poliomyelitis (Intermediate stage)	1, 24, 30, 31
24	Primary Pulmonary Hypertension / Pulmonary Arterial Hypertension	Early Pulmonary Hypertension	Secondary Pulmonary Hypertension	1, 25, 30, 31
25	Progressive Scleroderma	Early Progressive Scleroderma	Progressive Scleroderma with CREST syndrome	1, 26, 30, 31
26	Open Chest Surgery to Aorta	Minimally invasive surgery to Aorta or Large asymptomatic aortic aneurysm	-	1, 27, 30, 31
27	Systemic lupus erythematosus with lupus nephritis	Mild systemic lupus erythematosus	Moderately severe systemic lupus erythematosus with lupus nephritis	1, 28, 30, 31
28	Severe Encephalitis	Viral Encephalitis with full recovery	Moderate Viral Encephalitis with full recovery	1, 29, 30, 31

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

SECTION 1 : GENERAL INFORMATION							
1. Date when patient first consulted you for the condition?		DD		MM		YY	
2. When was the last consultation?		DD		MM		YY	
3. What were the presenting symptoms when you first saw the patient?							
4. When did the above symptoms first present?		DD		MM		YY	
5. Please provide exact diagnosis:							
6. What is/are the underlying cause(s)?							
7. Date of diagnosis.		DD		MM		YY	
8. Date when patient / patient's next of kin first informed of the diagnosis.		DD		MM		YY	
9. Please provide dates and details of investigation performed for the diagnosis. Kindly attach copies of all relevant objective test reports, which confirmed the diagnosis.							
10. Were you the doctor who first diagnosed the patient with this condition?						Yes	No
11. If Yes, over what period do your records extend?	From dd/mm/yy			To dd/mm/yy			
12. If you are not the first doctor who diagnosed the patient with this condition, please provide:							
a. Name and practice address of the doctor who first made the diagnosis or had treated the patient for this condition:							
b. Date the diagnosis was made by the previous doctor.		DD		MM		YY	
c. When was the referral made for the patient to see you?		DD		MM		YY	
d. What was the reason for referral to see you? Please attach a copy of the referral letter.							

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

SECTION 2 : ALZHEIMER'S DISEASE / SEVERE DEMENTIA / MODERATELY SEVERE ALZHEIMER'S DISEASE OR DEMENTIA		
1. Is there evidence of deterioration or loss of intellectual capacity or cognitive function?	Yes	No
2. Is there abnormal behavior resulting in significant reduction in mental and social functioning requiring the continuous supervision of patient?	Yes	No
3. If Yes to Q1 and/or Q2, please describe the extent of the disease and patient's behavior.		
4. Does the patient require continuous supervision as a result of the significant reduction in mental and social functioning described in Q2 & Q3?	Yes	No
If Yes, please provide the basis of your evaluation and state the date on which such continuous supervision was first required.		
5. Please describe the progression of the patient's Alzheimer's disease/dementia condition since the time he/she was first and last seen at the Hospital/clinic.		
6. Please circle your reply if the patient's deterioration or loss of intellectual capacity or abnormal behavior arises from any of the following?		
a. Non-organic disease such as neurosis and psychiatric illness?	Yes	No
b. Head injury related brain damage?	Yes	No
c. Alcohol related brain damage?	Yes	No
d. Drug related brain damage?	Yes	No
e. Any other disease/infections?	Yes	No
7. Was there permanent clinical loss of the ability to do any of the following:		
a. Remember	Yes	No
b. Reason	Yes	No
c. Perceive, understand, express and give effect to ideas	Yes	No

8. Please provide full details and results of all investigation (with dates) performed for the diagnosis. Please also attach a copy of all relevant test reports (e.g. Mini-Mental State Examination (MMSE) or other equivalent Alzheimer's tests) which confirmed the diagnosis.

Type of test/assessment	Date of test/assessment	Results of test/assessment

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

SECTION 3 : PERSISTENT VEGETATIVE STAGE (APALLIC SYNDROME)/ AKINETIC MUTISUM/ LOCKED IN SYNDROME		
1. Is there presence of universal necrosis of the brain cortex with the brainstem intact?	Yes	No
If Yes, please provide full details, including the neurological deficit.		
2. Is there organic brain damage which resulted in the patient's inability to talk or move despite being alert at times?	Yes	No
If yes, please provide details of organic brain damage suffered with supporting medical evidence.		
3. Is there inability to move or communicate verbally due to complete paralysis of all voluntary muscles in the body despite being aware?	Yes	No
4. Is there vertical eye movements and blinking?	Yes	No
5. Is there evidence of the following:		
i) Quadriplegia and inability to speak	Yes	No
ii) Infarction of the ventral pons	Yes	No
iii) EEG indicating that the patient is not unconscious	Yes	No
6. Did the condition persist for at least one month since its onset?	Yes	No
If Yes, please state the duration for which it persisted and to support with a copy of the medical documentation.		
7. Is the patient's condition expected to improve?	Yes	No
If Yes, please advise the extent of recovery and the duration to expect for such recovery to take place. / If No, please explain with supporting medical evidence.		
8. Is the patient's condition in a way related or due to AIDS or HIV related illness?	Yes	No
If Yes, please provide details.		

SECTION 4 : IRREVERSIBLE APLASTIC ANAEMIA / REVERSIBLE APLASTIC ANAEMIA / MYELODYSPLASTIC SYNDROME OR MYELOFIBROSIS		
1. Please provide full details of tests and results which have been performed to establish the diagnosis of Aplastic Anaemia.		
2. What is the cause of patient's aplastic anaemia?		
a. Acute reversible bone marrow failure?	Yes	No
b. Chronic persistent and irreversible bone marrow failure?	Yes	No
3. Was any of the following present? If Yes, please provide us with the relevant laboratory results.		
a. Anaemia?	Yes	No
b. Neutropenia?	Yes	No
c. Thrombocytopenia	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

4. Does the patient requires or has received any of the following treatment?		
a. Blood product transfusions?	Yes	No
b. Bone marrow stimulating agents?	Yes	No
c. Immunosuppressive agents?	Yes	No
d. □ Bone marrow transplantation; or □ Hematopoietic stem cell transplantation?	Yes	No
e. Chemotherapy?	Yes	No
5. Please provide details of treatment administered, including date/period of treatment, name and address of attending doctors.		
6. Was the patient's condition diagnosis of Myelodysplastic Syndrome (MDS) or Myelofibrosis confirmed on marrow biopsy?	Yes	No
7. Is the patient's condition in any way attributable to Human Immunodeficiency virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)?	Yes	No
If Yes to Q6 & Q7, please provide more details to your answer.		

SECTION 5 : SEVERE BACTERIAL MENINGITIS / BACTERIAL MENINGITIS WITH FULL RECOVERY

1. Is there severe inflammation of the membranes of the brain or spinal cord?	Yes	No
2. Please describe what are the patient's present limitations, physical and mental?		
3. Have the neurological deficits (described in Q2 above) last for a continuous period of at least 6 weeks?	Yes	No
4. Are these neurological deficits irreversible and permanent?	Yes	No

a. If Yes, please provide details of the deficits and elaborate with supporting evidence.	b. If No, please state date of recovery or date for which patient is likely to recover from these neurological deficits? (dd/mm/yy)

5. Was the condition present due to HIV / AIDS infections?	Yes	No
If Yes, please provide details including date of diagnosis, name and address of the doctor who first made the diagnosis.		

SECTION 6 : BLINDNESS (IRREVERSIBLE LOSS OF SIGHT) / LOSS OF SIGHT IN ONE EYE / OPTIC NERVE ATROPHY WITH LOW VISION

1. What is the patient's current visual acuity of both eyes using Snellen eye chart?

Visual acuity on **left eye**:	Visual acuity on **right eye**:
Date of assessment: (dd/mm/yy)	Date of assessment: (dd/mm/yy)

2. What is the patient's current visual field in both eyes?

Visual field on **left eye**:	Visual field on **right eye**:
Date of assessment: (dd/mm/yy)	Date of assessment: (dd/mm/yy)

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

3. Is the visual loss permanent and irreversible in one or both eyes?	Yes	No
If Yes, please indicate which eye is affected and to support your basis with the relevant medical reports.		
4. Will any surgical procedures, implants or other means of treatment improve or could reinstate patient's vision on either or both eyes? If Yes, please provide details.	Yes	No
a. Please state name and type of surgical procedure, implant or means of treatment.		
b. Has such treatment been recommended to patient?	Yes	No

If No, why is the reason?	If Yes, when is the scheduled date of surgery/ implant or commencement date of treatment? (dd/mm/yy)

c. Using the Snellen eye chart, what is the best corrected visual acuity of both eyes?	Left eye	Right eye

5. Has the patient suffered from Optic Nerve Atrophy with low vision? If Yes, please advise the following:	Yes	No
a. How was the diagnosis of optic nerve atrophy established?		
b. Are both eyes affected as a result of optic nerve atrophy? Please circle.	Yes	No
If Yes, please provide details.		

c. Using the Snellen eye chart, what is the best corrected visual acuity of both eyes?	Left eye	Right eye

6. Is the patient's condition resulting from alcohol or drug misuse?	Yes	No
If Yes, please provide us with the details.		

SECTION 7 : COMA / COMA FOR 48 HOURS / SEVERE EPILEPSY OR COMA FOR 72 HOURS

1. How was the diagnosis of Coma established? Please attach a copy of the diagnostic investigation reports (e.g. electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) etc.).		
2. Was there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for:		
a. At least 48 hours?	Yes	No
b. At least 72 hours?	Yes	No
c. At least 96 hours?	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

If Yes to any of the above, please support the basis with medical evidence.		If No to all of the above, please state how many hours was the patient in a state of coma, with no response to external stimuli?	
3.	Was the patient put on life support measures?	Yes	No
	If Yes, please advise the date patient was put on life support measures and details of such life support measures.		
4.	Had the patient woke up from the state of coma, with no response to external stimuli?	Yes	No
	If Yes, please state the date and time patient has woke up from the state of coma.		
5.	Was there any brain damage resulting in permanent neurological deficit?	Yes	No
	a. Has the neurological deficit lasted for more than 30 days from the onset of coma?	Yes	No
	b. Please provide date(s) of assessment and describe the neurological deficits presented during each visit.		
6.	Is the patient diagnosed with Epilepsy? If Yes, please state the following:	Yes	No
	a. How was the diagnosis of Epilepsy established?		
	b. 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, please state date(s) of attack(s) and the frequency of attack(s).		
	c. Is the patient taking prescribed anti-epileptic (anti-convulsant) medications?	Yes	No
	If Yes, please state the type(s) of medication and how long has patient been on such medication.		
7.	Is patient's condition resulting from alcohol, drug misuse or medically induced coma?	Yes	No
	If Yes, please provide us with the details.		

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

SECTION 8 : DEAFNESS (IRREVERSIBLE LOSS OF HEARING) / PARTIAL LOSS OF HEARING OR CAVERNOUS SINUS THROMBOSIS SURGERY / COCHLEAR IMPLANT SURGERY		
1. Was the diagnosis confirmed by an audiometric and sound-threshold?	Yes	No
2. Is there total loss of hearing in both ears?	Yes	No
3. What is the patient's current hearing ability in both ears (in decibels)? Hearing frequency in **left ear**: Hearing frequency in **right ear**: Date of assessment: (dd/mm/yy) Date of assessment: (dd/mm/yy)		
4. Is there a total loss in all frequencies of hearing of:		
a. at least 60 decibels	Yes	No
b. at least 80 decibels	Yes	No
5. Is the loss of hearing irreversible in both ears?	Yes	No
6. Can the hearing be restored to at least 40 decibels by medical treatment, hearing aid and/ or surgical procedures consistent with the current standard of the medical services?	Yes	No
If yes, how long does it take to restore the hearing to at least 40 decibels? _____ (number of months)		
7. Has the patient undergo surgery for Cavernous Sinus Thrombosis? If Yes, please state the following:	Yes	No
a. Type of surgery performed / b. Date the surgery was performed (dd/mm/yy)		
8. Has the patient undergone surgical cochlear implant?	Yes	No
a. Was there permanent damage to the cochlea or auditory nerve?	Yes	No
b. Please state the actual date of surgery. ____ DD ____ MM ____ YY		
9. Will any surgery improve or could reinstate patient's hearing on either or both ears? If Yes, please provide details.	Yes	No
a. Please state name and type of surgery?		
b. Has such surgery been recommended to patient?	Yes	No
If No, what is the reason? / If Yes, when is the scheduled date of surgery? (dd/mm/yy)		
c. What is the best corrected hearing frequency in both ears?	Left ear	Right ear

SECTION 9 : END STAGE LIVER FAILURE / LIVER SURGERY / LIVER CIRRHOSIS		
1. Was there end stage liver failure?	Yes	No
2. Please state the date where end stage liver failure was first diagnosed. ____ DD ____ MM ____ YY		

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

3. Was there evidence of permanent jaundice?						Yes	No
4. How long has the patient been affected by jaundice?							months
5. Was there evidence of ascites?						Yes	No
6. Please state the date where ascites was first discovered.		DD		MM			YY
7. Was there confirmation of ascites by paracentesis and/or by ultrasound?						Yes	No
If Yes, please provide details of the diagnostic findings and to attach a copy of the results.							
8. Was there evidence of hepatic encephalopathy?						Yes	No
If Yes, please provide details including dates, underlying causes, complications (if any) and treatment.							
9. Was there partial hepatectomy of at least one entire lobe of the liver? If Yes, please state the following:						Yes	No
a. Date the surgery was performed (dd/mm/yy)		b. Reason for requiring partial hepatectomy. Please support with evidence why surgery is absolutely necessary.					
10. Was there cirrhosis of liver? Please circle.						Yes	No
If Yes, please provide us with the HAI-Knodell Scores together with the liver biopsy result.							
11. What was the cause of the liver failure?							
12. Was the liver disease suffered by the patient secondary to alcohol abuse?						Yes	No
13. Was the liver disease suffered by the patient secondary to drug abuse?						Yes	No
If Yes to Q12 & Q13, please give details of the patient's habits in relation to alcohol assumption, including the amount of alcohol consumption per day and source of this information.							
14. What is the current condition of the patient and his/her prognosis?							

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

SECTION 10 : END STAGE LUNG DISEASE / SEVERE ASTHMA OR INSERTION OF A VENO-CAVA FILTER / SURGICAL REMOVAL OF ONE LUNG							
1. Please describe the patient's lung disease.							
2. Has the patient's lung disease reached end-stage? Please circle.						Yes	No
3. Please state the exact date patient's lung disease has reached end-stage.		DD		MM			YY
4. Is the patient's FEV_1 test results consistently less than 1 litre? Please circle.						Yes	No
If No, please state patient's FEV1 test result and to provide dates and details of all investigations carried out, including pulmonary function tests. To attach a copy of all the pulmonary function tests results.							
5. Does the patient require extensive and permanent oxygen therapy for hypoxemia?						Yes	No
a. Please advise the start date.		DD		MM			YY
b. Please state the frequency oxygen therapy is administered.							
6. Is the patient's arterial blood gas analysis with partial oxygen pressures of 55mmHg or less ($PaO_2 \leq$ 55mmHg)?						Yes	No
a. If Yes, please provide full details of all arterial blood gas analysis results.	b. If No, please give the actual readings.						
7. Is there dyspnea at rest? Please circle.						Yes	No
8. Please provide dates and details of all investigations carried out, including pulmonary function test, current FEV_1 and vital capacity readings.							
9. Is the patient suffering or has suffered from severe asthma condition? Please circle.						Yes	No
a. Was there evidence of an acute attack of severe asthma with persistent status of asthmaticus?						Yes	No
b. Was the patient hospitalized and required assisted ventilation with a mechanical ventilator?						Yes	No
i. Please advise date of admission.		DD		MM			YY
ii. Please advise date of discharge.		DD		MM			YY
iii. Is the patient on mechanical ventilator for a continuous period of at least 4 hours?						Yes	No
10. Is the patient suffering or has suffered from pulmonary emboli?						Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date

a. If Yes, please provide us with the first and subsequent dates, the presenting symptoms and diagnosis where the patient consulted you for each recurrence of pulmonary emboli.							
11. Has the patient undergone surgery to:						Yes	No
a. Insert vena-cava filter due to documented proof of recurrent pulmonary emboli?						Yes	No
b. Complete surgical removal of one lung as a result of an illness or an accident?						Yes	No
c. If Yes to Q11 (a) &/or (b), please state actual date of surgery.		DD		MM			YY
SECTION 11 : FULMINANT HEPATITIS / HEPATITIS WITH CIRRHOSIS OR BILIARY TRACT RECONSTRUCTION SURGERY / CHRONIC PRIMARY SCLEROSING CHOLANGITIS							
1. Please state the type of hepatitis virus diagnosed?							
2. What is the approximate date of commencement?		DD		MM			YY
3. Please provide the following information in relation to patient's diagnosis of fulminant hepatitis:							
a. Was a liver biopsy performed?						Yes	No
i. Please state date of biopsy?		DD		MM			YY
b. Was an abdominal ultrasound performed?						Yes	No
i. Please state date of ultrasound?		DD		MM			YY
c. Is there a submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure? If Yes, please advise:						Yes	No
i. Is there rapid decreasing of liver size?						Yes	No
If Yes, please advise the state of the liver and its lobular architecture.							
ii. Is there necrosis involving entire lobules, leaving only a collapsed reticular framework?						Yes	No
If Yes, please advise the extent of the liver necrosis and its lobular architecture.							
iii. Is there necrosis involving entire lobules, leaving only a collapsed reticular framework?						Yes	No
If Yes, please advise the extent of the liver necrosis and its lobular architecture.							
iv. Is there a rapid deterioration of liver function tests?						Yes	No
If Yes, please state the test results evident of the rapid deterioration and to attach a copy of the results.							

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v. Is there deepening jaundice?						Yes	No
If Yes, please give full details.							
vi. Is there evidence of hepatic encephalopathy?						Yes	No
If Yes, please give full details, including dates, underlying causes, treatment and any complications.							
4. Is there a submassive necrosis of the liver by the hepatitis virus leading to cirrhosis?						Yes	No
a. Please provide the Metavir grading.			b. Please provide the Knodell fibrosis score				
5. Has the patient undergone biliary tract reconstruction surgery involving choledochoenterostomy (choledochojejunostomy or choledochoduodenostomy) for the treatment of biliary tract disease, including biliary atresia? If Yes, please advise the following:						Yes	No
i. If Yes, please advise when was the biliary tract reconstruction surgery done?		DD		MM			YY
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
6. Is patient's condition of chronic primary sclerosing cholangitis confirmed by cholangiogram? If Yes, please advise the following:						Yes	No
i. Is there progressive obliteration of the bile ducts?						Yes	No
ii. Is there permanent jaundice?						Yes	No
iii. Is the patient's biliary tract sclerosis or obstruction a consequence of biliary surgery, gall stone disease, infection, cancer, inflammatory bowel disease or other secondary precipitants?						Yes	No
If Yes, please provide details.							
7. Was the patient's condition caused directly or indirectly by alcohol or drug abuse?						Yes	No
If Yes, please give details.							
8. What is patient's current condition and the prognosis?							
SECTION 12 : OPEN CHEST HEART VALVE SURGERY / PERCUTANEOUS VALVE SURGERY/ PERCUTANEOUS VALVE REPLACEMENT OR DEVICE REPAIR							
1. Please provide details of the heart disease leading to heart valve surgery.							
2. What is the date of onset of the heart valve abnormality?		DD		MM			YY

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3. Please state the date where heart valve disease was diagnosed.		DD		MM		YY
4. Was the diagnosis supported by cardiac catheterization?					Yes	No
a. If Yes, please give details and attach a copy of cardiac catheterization results.	b. If No, please provide the justification based on to confirm the diagnosis of heart valve abnormality.					
5. Was the diagnosis supported by echocardiogram?					Yes	No
a. If Yes, please give details and attach a copy of echocardiogram report.	b. If No, please provide the justification based on to confirm the diagnosis of heart valve abnormality.					
6. Was surgery performed to repair or replace the heart valve abnormality? If Yes, please provide details:					Yes	No
a. What was the date when heart valve disease **requiring surgery** was first diagnosed?		DD		MM		YY
b. Please state the date patient first became aware that heart valve surgery was necessary.		DD		MM		YY
c. Please state date of the surgery.		DD		MM		YY
d. Was there the deployment of a permanent device or prosthesis by percutaneous intravascular techniques not involving thoracotomy?					Yes	No
e. Please describe the surgical procedure used to correct the valvular problem (i.e. open heart surgery, percutaneous intravascular balloon valvuloplasty with OR without thoracotomy etc.)						
f. Was the surgery procedure stated in Q6(d) above a form of an open-heart surgery?					Yes	No
i. If No, please state exact form of intervention.						

SECTION 13 : HIV DUE TO BLOOD TRANSFUSION AND OCCUPATIONALLY ACQUIRED HIV / HIV DUE TO ASSAULT, ORGAN TRANSPLANT OR OCCUPATIONALLY ACQUIRED HIV

1. Was the infection due to:		
a. Blood transfusion	Yes	No
b. Organ transplant	Yes	No
c. Physical or sexual assault	Yes	No
2. Was the blood transfusion or organ transplant medically necessary or given as part of medical treatment?	Yes	No
3. Did the incident of infection occur in Singapore?	Yes	No
If Yes, please provide the exact date and details.		

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4. Was the infection resulted from any other means including sexual activity and the use of intravenous drugs?	Yes	No
If Yes, please state the likely cause:		
5. Was the incident of infection established to involve a definite source of the HIV infected fluids?	Yes	No
6. Was the incident of infection reported to the appropriate authority?	Yes	No
7. Is the institution where the blood transfusion or organ transplant was performed able to trace the origin of the HIV tainted blood?	Yes	No
8. Is the patient suffering from Thalassaemia Major or Haemophilia?	Yes	No
9. 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:		
10. Was there an accident whilst the patient was carrying out the normal professional duties of his/her occupation in Singapore? If Yes, please advise the following:	Yes	No
a. Please state the date of accident.	DD MM	YY
b. Was the accident involved a definite source of the HIV infected fluids?	Yes	No
11. Was an HIV antibody test done after the incident of infection?	Yes	No
If Yes, what was the result?		

SECTION 14 : LOSS OF INDEPENDENT EXISTENCE

1. Please elaborate in details the underlying cause of patient's condition?		
2. Please confirm if the patient's inability to perform any of the above activities of daily living is due to non-organic diseases such as neurosis or psychiatric illnesses	Yes	No
If Yes, please provide full details on the non-organic disease.		
3. Was the patient's condition a result of an accident? If Yes, please provide the following information:	Yes	No
a. What is date of accident?	DD MM	YY
b. Please describe where and how did the accident happened.		
c. Please describe the extent and severity of the bodily injuries/disability sustained, including exact site(s) of the body.		
If no, was it due to a self-inflicted injury?	Yes	No

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4. Please describe and elaborate on the nature and severity of the patient's physical disability and limitation.

5. Was there total and irreversible physical loss of all fingers including thumb of the same hand due to the above accident?					Yes	No
6. Please state date of last assessment in relation to patient's ability to perform activities of daily living?		DD		MM		YY

7. Based on the last date of assessment, please state your assessment if the patient is able to perform (whether aided* or unaided) the following Activities of Daily Living?
*Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (dd/mm/yy)	To (dd/mm/yy)
Washing : 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		
Dressing : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.	Yes	No		
Transferring : Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		
Mobility : Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	Yes	No		
Feeding : Ability to feed oneself food once food has been prepared and made available.	Yes	No		

8. What is the prognosis?
   a. If patient's condition is likely to improve, please state extent of improvement expected and estimated date of recovery.
   b. If the patient's condition is likely to deteriorate or remain static, please elaborate with reasons how you arrive at this opinion.

SECTION 15 : IRREVERSIBLE LOSS OF SPEECH / LOSS OF SPEECH DUE TO NEUROLOGICAL DISEASE OR NEUROLOGICAL INJURY OR PERMANENT OR TERMPORARY TRACHEOSTOMY

1. What is the date of onset patient loses the ability to speak?		DD		MM		YY
2. Has there been any improvement in the patient's speech since onset of the condition?					Yes	No
If No, please elaborate.						
3. Is the loss of speech as a result of injury to the vocal cords?					Yes	No
If Yes, please provide full and exact details, including date and the circumstance leading to the injury.						
4. Is the loss of speech as a result of disease to the vocal cords?					Yes	No

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If Yes, please provide full and exact details, including dates of diagnosis and treatments.		
5. If No to Q3 & Q4, what was the cause of the loss of speech?		
6. Is the loss of speech considered total and irrecoverable/ irreversible?	Yes	No
If Yes, please provide details of the investigation performed to confirm the loss is total and irrecoverable. Please attach a copy of the diagnostic test reports (e.g. fiberoptic nasolaryngoscopy, etc.)		
7. Will any surgery improve or could reinstate patient's ability to speak?	Yes	No
If Yes, please state what kind of surgery will be necessary and what is the tentative date of surgery?		
8. Did patient's inability to speak last for a continuous period of 12 months?	Yes	No
Please state the period of patient's inability to speak, including date of onset to last date of establishment.		
9. Were there any associated neurological or psychiatric conditions contributing to patient's loss of speech?	Yes	No
If Yes, please provide details on the date of diagnosis, exact diagnosis and contact details of attending doctor.		
10. Is the patient currently undergoing any speech therapy sessions?	Yes	No
a. If Yes, please state frequency and duration.	b. If No, please state the date of last speech therapy session.	

11. Has tracheostomy been performed?					Yes	No
a. When was tracheostomy done?		DD		MM		YY
b. What is the purpose of doing a tracheostomy?						
c. Was tracheostomy performed for treatment of lung or airway disease or a ventilator support measure following major trauma or burns?					Yes	No
If Yes, please give details on the purpose and the reason why it was required.						
d. Was the tracheostomy performed for the purpose of saving life?					Yes	No
If Yes, please provide more details to your answer.						
e. Was the tracheostomy tube in place and functional for a period of at least 3 months?					Yes	No
f. What is the date tracheostomy tube is removed?		DD		MM		YY

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SECTION 16 : MAJOR BURNS / MODERATELY SEVERE BURNS						
1. What is date of incident resulting in major burns?		DD		MM		YY
2. Where and how did the incident happen resulting in the major burns?						
3. Is there reason to suspect that there were contributory circumstances which led to the burns injury, e.g. under the influence of alcohol, drugs, suicide or attempted suicide, etc.?					Yes	No
If Yes, please elaborate with details.						
4. Were the major burns a result of an accident? If Yes, please provide the following information:					Yes	No
a. What is date of incident resulting in major burns?		DD		MM		YY
b. Where and how did the accident happen resulting in the major burns?						
c. Was there a police report made with regard to this accident? If Yes, please provide a copy.					Yes	No
5. Is the burns result from a self-inflicted act?					Yes	No
If Yes, please provide details.						
6. Please state the areas affected on the patient's body, the percentage of surface area, and the degree of burns in each affected area and to attach a copy of the burns report.						

Area affected	Percentage of surface area	Degree of burns

a. Please confirm if the patient suffered from burns resulting in full thickness skin destruction of **at least 10%** of his/her body surface?					Yes	No
b. Please confirm if the patient suffered from Second Degree (partial thickness of the skin) burns covering **at least 20%** of the surface of his/her body?					Yes	No
c. Please confirm if the patient suffered from Third Degree (full thickness of the skin) burns covering **at least 20%** of the surface of his/her body?					Yes	No
d. Please confirm if the patient suffered from Third Degree burns covering **at least 25%** of his/her body surface?					Yes	No
e. Please confirm if the patient suffered from Third Degree (full thickness of the skin) burns covering **at least 50%** of his/her face?					Yes	No
7. Has the patient undergone any skin grafts to repair damaged skin?					Yes	No
a. If Yes, please state the date of skin grafting?		DD		MM		YY
8. Has the patient undergone any surgical debridement under general anesthetic?					Yes	No
a. If Yes, please state the date of surgical debridement?		DD		MM		YY
9. Please state other alternative of treatments patient has received, beside skin grafting and/or surgical debridement.						

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SECTION 17 : MAJOR HEAD TRAUMA / FACIAL RECONSTRUCTIVE SURGERY OR SPINAL CORD INJURY / INTERMEDIATE STAGE MAJOR HEAD TRAUMA							
1. What is date of accident resulting in major head trauma?		DD		MM		YY	
2. Where and how did the accident happen leading to major head trauma?							
3. Is there reason to suspect that there were contributory circumstances which led to the injury, e.g. under the influence of alcohol, drugs, fits, etc.?						Yes	No
If Yes, please provide details. (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.)							
4. Was there a police report made with regard to this accident? If Yes, please provide a copy.						Yes	No
5. Was the head injury due to a self-inflicted act?						Yes	No
6. Was the head injury due to participation or attempted participation in an unlawful act?						Yes	No
7. Was there any form of neurological deficit still present 6 weeks after the date of accident?						Yes	No
If Yes, please state the neurological deficits(s).							
8. Is the neurological deficit described in Q7 likely to be permanent (i.e. lasting throughout patient's lifetime)?						Yes	No
a. If Yes, please support your basis with evidence.	b. If No, please state date of recovery or date which the patient is expected to recover from neurological deficit. (dd/mm/yy)						
9. Did the patient suffered from facial injury? If Yes, please provide the following information:						Yes	No
a. What is date of accident resulting in facial injury?		DD		MM		YY	
b. Where and how did the accident happen leading to facial injury?							
c. Please provide details of any facial injuries sustained.							
d. Was there any reconstructive surgery above the neck (restoration or reconstruction of the shape of, and appearance of facial structures which were defective, missing or damaged or misshapen) to correct disfigurement as a direct result of the accident?						Yes	No
i. If Yes, please provide dates and details of the surgery performed.							
e. Was the reconstructive surgery solely for treatment relating to teeth and/or any other dental restoration alone and/or cosmetic nose surgery?						Yes	No
10. Did the patient suffered from accidental cervical spinal cord injury? If Yes, please provide following:						Yes	No
a. What is date of accident resulting in cervical spinal cord injury?		DD		MM		YY	
b. Where and how did the accident happen leading to cervical spinal cord injury?							

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c. Please describe the exact nature of the cervical spinal cord injury sustained.							
d. 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
i. If Yes, please describe and elaborate on the extent and severity of the patient's loss of use of his/her limb.							
11. Did patient undergo any surgery for treatment of head injury? If Yes, please provide the following:						Yes	No
a. What is the date of surgery?		DD		MM			YY
b. Did patient undergo an open craniotomy surgery?						Yes	No
c. Did patient undergo burr hole surgery?						Yes	No
SECTION 18 : MAJOR ORGAN/ BONE MARROW TRANSPLANTATION / SMALL BOWEL TRANSPLANT OR CORNEAL TRANSPLANT/ MAJOR ORGAN OR BONE MARROW TRANSPLANT ON WAITLIST							
1. Date when illness/condition necessitating organ transplant was first diagnosed.		DD		MM			YY
2. When did patient first become aware of the illness/condition requiring transplant?		DD		MM			YY
3. What is the exact date of transplant?		DD		MM			YY
4. Was the patient on official organ transplant waiting list for the receipt of a transplant of:							
a. human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation; or						Yes	No
b. one of the human organs: heart, lung, liver, kidney or pancreas that resulted from irreversible end stage failure of the relevant organ						Yes	No
5. Was the patient a recipient of a human bone marrow transplant? If Yes, please advise:						Yes	No
a. Date the human bone marrow transplant was done.		DD		MM			YY
b. Was the source of the transplanted bone marrow obtained from another human bone marrow?						Yes	No
c. Was the receipt of bone marrow transplant using haematopoietic stem cells preceded by total bone marrow ablation?						Yes	No
6. Was the patient a recipient of human organ transplantation? If Yes, please advise:						Yes	No
a. What is the exact date of organ transplant?		DD		MM			YY
b. Which human organ is transplanted?							
c. Was the transplant resulted from an irreversible end stage failure of the relevant organ?						Yes	No
d. What is the exact date the relevant organ has reached its end-stage?		DD		MM			YY
7. Was the patient a recipient of small bowel transplant? If Yes, please advise:						Yes	No
a. What is the exact date of small bowel transplant?		DD		MM			YY
b. Please confirm if there is receipt of at least one metre of small bowel transplanted via a laparotomy due to intestinal failure?						Yes	No
c. When is the onset date of patient's intestinal failure?		DD		MM			YY

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8.	Was the patient a recipient of a whole corneal transplant? If Yes, please advise:					Yes	No
	a. What is the exact date of corneal transplant?		DD		MM		YY
	b. Was the transplant due to irreversible scarring with resulting reduced visual acuity which cannot be corrected with other methods?					Yes	No
	Please provide more details to your answer in Q7(b).						

SECTION 19 : MOTOR NEURONE DISEASE / EARLY MOTOR NEURONE DISEASE OR PERIPHERAL NEUROPATHY

1.	Please provide full and exact diagnosis of the patient's condition (including type of motor neurone disease e.g. amyotrophic lateral sclerosis, progressive bulbar palsy, spinal muscular atrophy and primary lateral sclerosis).		
2.	Is the patient's motor neurone disease characterized by progressive degeneration of:		
	a. corticospinal tracts?	Yes	No
	b. anterior horn cells?	Yes	No
	c. bulbar efferent neurons?	Yes	No
	If Yes to any of the above, please provide more details to your answer.		
3.	Please provide details of any investigations performed (e.g. electromyography, nerve conduction studies, MRI brain scan, muscle biopsy, spinal tap or lumbar puncture etc.). Please attach a copy of all investigation reports.		
4.	Please describe in full details, including examination dates of the neurologic system, the extent and progression of patient's condition.		
5.	Are the neurological deficits described in Q4 likely to be permanent?	Yes	No
	Please provide more details to your answer.		
6.	Is patient's condition peripheral neuropathy? If Yes, please advise:	Yes	No
	a. If the peripheral neuropathy has resulted in significant motor weakness?	Yes	No
	b. If the peripheral neuropathy has resulted in fasciculation?	Yes	No
	c. If the peripheral neuropathy has resulted in muscle wasting?	Yes	No
	d. Is the patient condition of peripheral neuropathy evident in nerve conduction studies?	Yes	No
	e. Is there a permanent need for the use of walking aids or a wheelchair?	Yes	No
7.	Is the patient's condition arising from diabetic neuropathy?	Yes	No
8.	Is the patient's condition arising from excessive alcohol consumption?	Yes	No
	If Yes to Q7 & Q8, please provide more details to your answer.		

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SECTION 20 : MULTIPLE SCLEROSIS / EARLY MULTIPLE SCLEROSIS / MILD MULTIPLE SCLEROSIS		
1. Please provide details, including dates, of the extent of the patient's neurological deficit.		
2. Are there multiple neurological deficits which occurred over a continuous period of:		
a. at least 3 months?	Yes	No
b. at least 6 months?	Yes	No
If Yes to any of the above, please give details, including dates of each episode.		
3. Is there a well-documented history of repeated relapse and remission of a steady progressive disability?	Yes	No
If Yes, please provide details, including dates of each episode.		
4. Was the neurological damage caused by Systemic Lupus Erythematosus (SLE) or Human Immunodeficiency Virus (HIV)?	Yes	No
If Yes, please provide more details to your answer.		
5. Please provide details of any investigations performed and comment if the diagnosis was supported by objective test including blood test and MRI / CT scanning. Please attach a copy of all investigation reports		
6. Please describe in full details, including examination dates, of the patient's current limitations in relation to his/her physical and mental state?		

SECTION 21 : MUSCULAR DYSTROPHY / MODERATELY SEVERE MUSCULAR DYSTROPHY OR SPINAL CORD DISEASE OR INJURY RESULTING IN BOWEL AND BLADDER DYSFUNCTION		
1. Is there any evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex?	Yes	No
If Yes, please describe the findings.		
2. What are the muscles involved?		
3. Was the diagnosis confirmed by an electromyogram?	Yes	No
4. Was the diagnosis confirmed by muscle biopsy?	Yes	No

5. Is the patient able to perform (whether aided* or unaided) the following Activities of Daily Living?
*Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (dd/mm/yy)	To (dd/mm/yy)
Washing : 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		
Dressing : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.	Yes	No		
Transferring : Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		

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Mobility : Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	Yes	No		
Feeding : Ability to feed oneself food once food has been prepared and made available.	Yes	No		

6. Is the patient's condition spinal cord disease or cauda equina injury?	Yes	No
a. If Yes, please advise which particular level or area of the spinal cord was affected by the disease or injury?		
7. Has the patient's neurologic condition resulted in permanent bowel dysfunction and bladder dysfunction? If Yes, please advise:	Yes	No
a. Is there permanent dysfunction requiring permanent regular self-catheterisation or permanent urinary conduit?	Yes	No
b. Has the bowel and bladder dysfunction lasted for at least 6 months?	Yes	No

i. If Yes to Q7(b), please provide exact date of onset.		DD		MM		YY

SECTION 22 : PARALYSIS (IRREVERSBILE LOSS OF USE OF LIMBS) / LOSS OF USE OF ONE LIMB / LOSS OF USE OF ONE LIMB REQUIRING PROSTHESIS

1. When was the date of onset?		DD		MM		YY

2. Please state the limb(s) involved and the extend of loss of use:

Please circle the specific limbs involved	Please describe the extent of loss of use	Please circle if the loss of use total and irreversible	
Left Upper Limb		Yes	No
Left Lower Limb		Yes	No
Right Upper Limb		Yes	No
Right Lower Limb		Yes	No

3. If the loss of use of the involved limb(s) is total and irreversible, please provide more details to your answer in Q2 and advise the first date of such continuous loss of use.		
4. Please confirm if the paralysis or loss of use of limb(s) has persisted for at least 6 weeks?	Yes	No

a. Please provide the exact date of onset.		DD		MM		YY

5. Please confirm if the patient underwent fitting and use of prosthesis to the affected limb(s)?	Yes	No
6. What was the underlying cause of patient's paralysis or loss of use of limb(s)?		
a. If due to illness, please give full details including diagnosis and date of diagnosis.	b. If due to injury, please give full details including date of accident, how it happened and nature of injury.	
7. Did the paralysis or loss of use of limb(s) resulting from a self-inflicted act?	Yes	No
8. Did the paralysis or loss of use of limb(s) resulting from alcohol misuse?	Yes	No
9. Did the paralysis or loss of use of limb(s) resulting from drug misuse?	Yes	No

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SECTION 23 : IDIOPATHIC PARKINSON'S DISEASE / EARLY AND MODERATELY SEVERE PARKINSON'S DISEASE

1. What is the cause of the patient's diagnosis of Parkinson's Disease?

2. Please confirm if the patient's diagnosis of Parkinson's Disease due to drug-induced causes?	Yes	No
3. Please confirm if the patient's diagnosis of Parkinson's Disease due to toxic causes?	Yes	No
4. Please confirm if the patient's diagnosis of Parkinson's Disease idiopathic in nature?	Yes	No
5. Can the patient's condition be controlled with medication?	Yes	No

If Yes, please give details of current treatment prescribed, including the name and dosage of medication, and date medical treatment first started.

6. Are there signs of progressive impairment?	Yes	No

If Yes, please describe in details, including dates, of the extent of neurological deficit suffered by patient and how his/her condition has deteriorated over time.

7. Is the patient able to perform (whether aided* or unaided) the following Activities of Daily Living?
*Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (dd/mm/yy)	To (dd/mm/yy)
Washing : 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		
Dressing : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.	Yes	No		
Transferring : Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		
Mobility : Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	Yes	No		
Feeding : Ability to feed oneself food once food has been prepared and made available.	Yes	No		

8. Was the Parkinson's Disease a 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 give full details including date of diagnosis, name and address of the doctor who made the diagnosis and source of information.

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SECTION 24: POLIOMYELITIS		
1. Was poliovirus the underlying cause of patient's condition?	Yes	No
a. If Yes, please provide details on poliovirus? / b. If No, what was the cause of patient's poliomyelitis?		
2. What is the current condition of the patient and what is the prognosis?		
3. Was there paralysis of the limb muscles?	Yes	No
If Yes, please describe the extent of patient's paralysis resulting from poliomyelitis.		
4. Was there paralysis of the respiratory muscles?	Yes	No
If Yes, please state if there was support by ventilator for a continuous period of minimum 96 hours	Yes	No
Please describe the impaired respiratory weakness resulting from poliomyelitis.		
5. For how long has the patient been suffering from the impaired motor function and/or respiratory weakness from its occurrence? Please **attach a copy** of the medical documentation.	months	
6. Is patient's condition peripheral motor neuropathy? If Yes, please advise:	Yes	No
a. If the peripheral neuropathy has resulted in significant motor weakness?	Yes	No
b. If the peripheral neuropathy has resulted in fasciculation?	Yes	No
c. If the peripheral neuropathy has resulted in muscle wasting?	Yes	No
d. Is the patient condition of peripheral neuropathy evident in nerve conduction studies?	Yes	No
e. Is there a permanent need for the use of walking aids or a wheelchair?	Yes	No
7. Is the patient's condition arising from diabetic neuropathy?	Yes	No
8. Is the patient's condition arising from excessive alcohol consumption?	Yes	No
If Yes to Q7 & Q8, please provide more details to your answer.		

SECTION 25 : PRIMARY PULMONARY HYPERTENSION / EARLY PULMONARY HYPERTENSION / SECONDARY PULMONARY HYPERTENSION / PULMONARY ARTERIAL HYPERTENSION		
1. Is the pulmonary hypertension due to primary cause?	Yes	No
2. Is the pulmonary hypertension due to secondary cause?	Yes	No
3. Were there presence of right ventricular hypertrophy, dilation and signs of right heart failure and decompensation?	Yes	No
4. Was there dyspnea and fatigue?	Yes	No
5. Was there increased left arterial pressure of at least 20mmHg?	Yes	No
6. Was there pulmonary resistance of at least 3 units above normal?	Yes	No
7. Was there pulmonary artery pressure of at least 40mmHg?	Yes	No
8. Was there pulmonary wedge pressure of at least 6mmHg?	Yes	No

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9. Was there right ventricular end-diastolic pressure of at least 8mmHg?	Yes	No
10. Was cardiac catheterization performed to establish the pulmonary hypertension?	Yes	No
If Yes, please provide evidence of the investigation and attach a copy of the report.		
11. Was there permanent physical impairment which fulfills the NYHA classification of cardiac impairment?	Yes	No
If Yes, please circle the appropriate class of impairment in accordance with the NYHA Classification of Cardiac Impairment: **NYHA Class I** **NYHA Class II** **NYHA Class III** **NYHA Class IV**		
12. Please describe the patient's current symptoms / physical activity impairment in relation to his/her class of impairment.		
13. Please confirm if such impairments (as described in Q12) are likely to be permanent?	Yes	No
If Yes, please explain.		

SECTION 26 : PROGRESSIVE SCLERODERMA / EARLY PROGRESSIVE SCLERODERMA / PROGRESSIVE SCLERODERMA WITH CREST SYNDROME

1. Please advise which form of scleroderma does the patient have?		
a. Localized scleroderma (linear scleroderma or morphea)	Yes	No
b. Eosinophilic fasciitis	Yes	No
c. CREST syndrome	Yes	No
d. Systemic scleroderma	Yes	No
If Yes to any of the above, please provide a description of the extent of the illness and the date of first diagnosis.		
2. Does the illness involve the followings:		
a. Skin with deposits of calcium (calcinosis)	Yes	No
b. Skin thickening of the fingers or toes (sclerodactyly)	Yes	No
c. The esophagus	Yes	No
d. Telangectasia (dilated capillaries)	Yes	No
e. Raynaud's Phenomenon causing artery spasms in the extremities	Yes	No
f. The heart	Yes	No
g. The lungs	Yes	No
h. The kidneys	Yes	No
Please provide more details to your answer above.		
3. Please provide details of investigation performed, with dates, including biopsy and serological evidence. Please attach a copy of the biopsy or equivalent confirmatory test and serology reports.		

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4. Please provide details of treatment prescribed, with dates (e.g. immunosuppressive therapy, anti-fibrotic agents, etc.).							
SECTION 27 : SURGERY TO THE AORTA / MINIMALLY INVASIVE SURGERY TO AORTA OR LARGE ASYMPTOMATIC AORTIC ANEURYSM							
1. On what date did the patient first become aware of the condition necessitating surgery?		DD		MM		YY	
2. What was the type of surgery performed? Please describe the surgical procedure in detail.							
a. Was surgery performed to repair or correct an aneurysm?						Yes	No
b. Was surgery performed to repair or correct narrowing or obstruction of the aorta?						Yes	No
c. Was surgery performed to repair or correct dissection of the aorta?						Yes	No
d. Was surgery performed through surgical opening of the chest or abdomen?						Yes	No
e. Was surgery performed on the thoracic aorta?						Yes	No
f. Was surgery performed on the abdominal aorta?						Yes	No
g. Was surgery performed using minimally invasive or intra-arterial techniques?						Yes	No
If Yes to any of the above, please provide more details to your answer.							
3. Please state exact date of surgery.		DD		MM		YY	
a. If surgery was not performed, please state degree of aortic aneurysm or dissection. Please attach a copy of tests results.							
4. Please state which of the following condition does patient has:							
a. Abdominal aortic aneurysm						Yes	No
b. Abdominal Aortic Dissection						Yes	No
c. Thoracic Aortic Aneurysm						Yes	No
d. Thoracic Aortic Dissection						Yes	No
Please provide details leading to the diagnosis of the abdominal or thoracic aortic aneurysm or dissection.							
5. Was there enlargement of the aorta?						Yes	No
If Yes, please state the diameter of the enlargement in millimeter.						mm	
6. Has the patient suffered or is suffering from any related illnesses e.g. hypertension, angina, vascular disease or endocarditis?						Yes	No
If Yes, please give date(s) of consultations and the resulting diagnosis.							

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SECTION 28 : SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS / MILD SYSTEMIC LUPUS ERYTHEMATOSUS		
1. Did the patient present with any of the following conditions:		
a. malar rash	Yes	No
b. discoid rash	Yes	No
c. photosensitivity	Yes	No
d. oral ulcers	Yes	No
e. arthritis	Yes	No
f. serositis	Yes	No
g. renal disorder	Yes	No
h. leukopenia (<4,000/mL)	Yes	No
i. lymphopenia (<1,500/ mL)	Yes	No
j. haemolytic anaemia	Yes	No
k. thrombocytopenia	Yes	No
l. neurological disorder	Yes	No
2. Was the patient tested positive for any of the following tests:		
a. anti-nuclear antibodies	Yes	No
b. L.E. cells	Yes	No
c. anti-DNA	Yes	No
d. anti-Sm (Smith IgG autoantibodies)	Yes	No
3. Is patient currently receiving systemic lupus immunosuppressive therapy due to involvement of multiple organs? Please circle.	Yes	No
a. Please state the first treatment date of immunosuppressive therapy.	D D / MM /	YY
b. Since the commencement date of immunosuppressive therapy, has the therapy lasted for a period of at least 6 months? Please circle.	Yes	No
i. If No, what is the reason that it did not persist for a period of at least 6 months?		
4. Are the following internal organs involved:		
e. kidneys	Yes	No
f. brain	Yes	No
g. heart or pericardium	Yes	No
h. lungs or pleura	Yes	No
i. joints in the presence of polyarticular inflammatory arthritis	Yes	No
If Yes to any of the above, please describe the nature and extent of the impairment, with dates(s).		

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5. Has the patient's Systemic Lupus Erythematosus lead to any kidneys involvement?	Yes	No
a. Was renal biopsy performed?	Yes	No

i. Please state the exact date biopsy was done and to elaborate on the biopsy result to establish the diagnosis of Systemic Lupus Erythematosus with Lupus Nephritis.

b. Based on the biopsy results, please circle the appropriate staging of the patient's lupus nephritis in accordance with the RPS/ ISN Classification of Lupus Nephritis.

Class I	**Class II**	**Class III**	**Class IV**	**Class V**	**Class VI**
Minimal Mesangial Lupus Nephritis	Mesangial Proliferative Lupus Nephritis	Focal Lupus Nephritis (active and chronic; proliferative and sclerosing)	Diffuse Lupus Nephritis (active and chronic; proliferative and sclerosing; segmental and global)	Membranous Lupus Nephritis	Advanced Sclerosis Lupus Nephrits

c. Based on the biopsy results, please circle the appropriate staging of the patient's lupus nephritis in accordance with the WHO Classification of Lupus Nephritis.

Class 1	**Class II**	**Class III**	**Class IV**	**Class V**
Minimal Change Lupus Glomerulonephrits	Mesangial Lupus Glomerulonephritis	Focal Segmental Proliferative Lupus Glomerulonephritis	Diffuse Proliferative Lupus Glomerulonephritis	Membranous Lupus Glomerulonephritis

d. Please state the creatinine clearance rate (e.g. mL per minute or less)

6. Please provide details of the investigations/test performed and attach copies of the results that confirm patient's diagnosis and WHO classification of lupus nephritis. E.g. blood tests, urinalysis, ultrasound scans of the kidneys, and a kidney biopsy.

7. Is the patient's condition a diagnosis of discoid lupus?	Yes	No
8. Is the patient's condition a diagnosis involving any form of hematologic abnormalities?	Yes	No

If Yes to Q5 &/or Q6, please provide details.

SECTION 29 : SEVERE ENCEPHALITIS / VIRAL ENCEPHALITIS WITH FULL RECOVERY / MODERATE VIRAL ENCEPHALITIS WITH FULL RECOVERY

1. What was the cause of the encephalitis (e.g. viral, bacterial etc) _____

2. Was the patient hospitalized?		Yes	No
a. If Yes, please state the period of hospitalization.	From dd/mm/yy	To dd/mm/yy	
3. Did patient have any significant and serious permanent neurological deficits?		Yes	No
4. Are the permanent neurological deficits documented for at least 6 weeks?		Yes	No

On Q3 & Q4, please provide more details, including dates, on the extent and length of persistence of the deficits to your answer.

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5.	Has the patient recovered to its normal functional state prior to the episode of encephalitis?						Yes	No
	a. If Yes, please provide the exact date patient has returned to his/her normal activities.		DD		MM			YY
6.	Was the condition caused by HIV infections?						Yes	No
	If Yes, please provide more details to your answer.							

SECTION 30 : OTHER INFORMATION

1.	Has the patient's condition resulted in him/her to be physically or mentally disabled from ever continuing in any employment? If Yes, please state:						Yes	No
	a. What were the patient's main physical or mental impairment and the severity of these limitations?							
	b. What is your reason that the patient is incapable of any employment throughout his/her lifetime?							
	c. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is patient mentally incapacitated?						Yes	No
2.	Is the patient's condition or surgery performed in any way related or due to:-							
	a. AIDS, AIDS-related complex or infection by HIV?						Yes	No
	b. Drug abuse or use of drug not prescribed by registered medical practitioner?						Yes	No
	c. Alcohol abuse or misuse?						Yes	No
	d. Congenital anomaly or defect?						Yes	No
	e. Attempted suicide or self-inflicted injuries?						Yes	No
	If Yes for any of the above, please provide the following details and also attach a copy of the test result.							
	f. Please indicate the diagnosis date.		DD		MM			YY
	g. Name and practice address of the doctor who first diagnosed the patient with HIV, AIDS, drug abuse, alcohol abuse or congenital anomaly.							

3.	Has the patient previously suffered from the condition described above or any related illness? If Yes, please provide the details below:						Yes	No

Diagnosis	Date of diagnosis	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

4.	Is there anything in patient's medical history which would have increased the risk of his/her condition?	Yes	No
	If Yes, please state the details.		

Name and Signature of the Medical Specialist who filled up Part II	Date

Name of Patient: NRIC / Passport No. of Patient:

5. Does the patient have or ever had any other significant health condition? If Yes, please provide:				Yes	No
Diagnosis	Date of diagnosis	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor	

Name and Signature of the Medical Specialist who filled up Part II	Date
Practice Stamp of the Medical Specialist	

SECTION 31
Attachment of Laboratory Reports

To enable us to proceed with the claim, it is mandatory to enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.

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