

ATTENDING PHYSICIAN'S STATEMENT (OSTEOGENESIS IMPERFECTA)

Policy No.
Claim No. <small>(For internal use)</small>

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:

This is characterised by brittle, osteoporotic, easily fractured bones. The Life Insured must be diagnosed as a Type III Osteogenesis Imperfecta confirmed by the occurrence of all of the following conditions:

- (a) the result of physical examination of the Life Insured by a Medical Examiner appointed by the Company confirming that the Life Insured suffers from growth retardation, walking difficulty, hearing impairment; and***
- (b) the result of X-ray studies reveals diffuse and severe osteoporotic bones with multiple fractures and progressive kyphoscoliosis; and***
- (c) positive result of skin biopsy.***

Diagnosis of Osteogenesis Imperfecta must be confirmed by a qualified paediatrician.

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

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

- (c) What are the signs or symptoms presented at that time?

Signs or Symptoms presented	Date first appeared

(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) Did you refer the patient to any other doctor(s)? Yes No

If yes, please provide the name and address of the doctor(s).

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

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

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp