

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

***Spina bifida means a defective closure of the spinal column due to a neural tube defect with a resultant meningocele or meningocele. Spina bifida occulta is excluded.***

(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 at that time	Date first appeared





(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).

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

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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**