

ATTENDING PHYSICIAN'S STATEMENT (HYSTERECTOMY)

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:
	Hysterectomy means the surgical removal of the body of the uterus, leaving the cervix, or removal of the entire uterus, either through an incision in the abdominal wall or through the vagina by a Medical Examiner. Hysterectomy due to any of the following reasons is excluded: (i)miscarriage (ii)therapeutic or elective abortion (iii)embedded intrauterine device or any other contraception means (iv)bleeding after intercourse (v)sex change
	(a) Please describe the exact details of the patient's condition.
	(b) Date you were first consulted for the condition:/
	(c) What symptoms did the patient complain of when she first saw you for this condition?
	(d) According to the patient, how long has she been experiencing these symptoms?

Manulife (Singapore) Pte Ltd.

Reg. No. 198002116D

Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424

	What was the diagnosis?
(g)	Date when the condition was first diagnosed://
(h)	Date when the patient first became aware of the condition necessitating surgery://
	Has the patient suffered any previous episodes of the underlying condition or any other condition leading to or relating to it? If yes, please give details.
(j)	Are you aware of any members of the patient's close family who have suffered from this or any si condition? If yes, please give details.
(k)	Type of surgery or procedure performed:
	Type of surgery or procedure performed:
(I)	
(l) (m)	Reason(s) for surgery:
(l) (m)	Reason(s) for surgery:

Manulife (Singapore) Pte Ltd.

Reg. No. 198002116D Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424

both b	e give details of the past and present.	patient	s habits in relation to	alconol, olgarotto cilio	
MEDICA	L HISTORY				
(a) If the r	patient was referred	I from a	clinic or hospital, ple	ase state:	
(i)			•		
(ii)	Name of clinic/ h	ospital	:		
(iii)	Date referred: _				
(b) D: ! !!	a madant as the st		tana fan de i- ill	ten nomentaria ()	
		ner doc	tors for this illness or	its symptoms before sl	ne consulted you?
□ Yes		nama	(a) and addraga(aa) a	f the destar(s) where s	ha aanaultad
ii yes		name	District	f the doctor(s) whom s	
	Name of Doctor		Name of Clinic/ Ho	ospital and Address	Dates of Consultat
			ĺ.		
					D
			i a		-
		l		-::6:	V
(a) la tha .	patient suffering or			significant illnesses?	□ Yes □
	please provide the		iliu iliioilliailoli io us.		
	, please provide the	1	-		
	, please provide the	1	of first Diagnosis	Name and Addres	s of Attending Docto
		1		Name and Addres	s of Attending Docto
		1		Name and Addres	s of Attending Docto
		1		Name and Addres	s of Attending Docto
		1		Name and Addres	s of Attending Docto
		1		Name and Addres	s of Attending Docto
		1		Name and Addres	s of Attending Docto

Manulife (Singapore) Pte Ltd.

Reg. No. 198002116D Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424

(d) Are you the patient's regular doctor?		No
If yes, since when?/	уууу	
If no, please provide the name and addre	ss of the patient's regular doctor.	
(e) Please give any other information which y	ou feel would be helpful in assessment of the patient	's c
	orts together with any tests or similar evidence to su	ppo
validity of the patient's claim.		
Signature of Doctor	Date	1
		60
	Address 9 Official Ctamp	200
	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	
Name and Qualification (printed)	Address & Official Stamp	

Manulife (Singapore) Pte Ltd.

Reg. No. 198002116D Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424