

ATTENDING PHYSICIAN'S STATEMENT (SPINA BIFIDA)

Policy No.	
Claim No. (For internal use)	

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

Name of the Patient:		NRIC/I	Passport No:
Date of Birth:	Sex:	_ Admission No:	Ward No:
Date of Admission:		Date of Discharge	•
DETAILS OF PATIENT'S	CONDITION		
In order for a claim und	er this policy to be	paid, the following de	finition must be satisfied:
Spina bifida means a de resultant meningomyele	efective closure of a	the spinal column due ele. Spina bifida occult	to a neural tube defect with a rais excluded.
(a) Please describe the ex	act details of the pat	ient's condition.	
(b) Date you were first cor	nsulted for the condit	ion:/_	
(b) Date you were first cor			
(c) What are the signs or s		at that time?	_/
(c) What are the signs or s	symptoms presented	at that time?	
(c) What are the signs or s	symptoms presented	at that time?	
(c) What are the signs or s	symptoms presented	at that time?	
(c) What are the signs or s	symptoms presented	at that time?	
(c) What are the signs or s	symptoms presented	at that time?	

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

(e) Dai	e when the condition was first diagnosed://		
	you aware of any members of the patient's close family who have suffered from the patient f	om this or an	y ¬ N
	ase complete the following section relating to your patient's condition. Please confirm the diagnosis of Spina Bifida as described above.		
(ii)	Please give full details of all investigations performed in relation to this condi	tion and their	results
(iii)	Type of treatment/ medication given.		
	Has the operation been performed?	□ Yes	□ N
(iv)			
	Please give full details of the operation performed		

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

	as there any indica ot be normal or he		ng her gestation th	at she may face c	omplica	ition or the baby □ Yes	/ may
		•	e and details of te	sts or examination	s done.		
(ii) Da	ate when condition	n was firs	t diagnosed:	// _	уууу		
(iii) D	ate she was inforn	ned of he	er condition:	//	уууу		
MEDICA	L HISTORY						
(a) If the	patient was referre	ed from a	clinic or hospital,	olease state:			
(i)							
(ii)							
(iii)	Date referred:						
	•		.015 101 11115 11111655	or its symptoms b	efore he	e/ she consulted	you?
□ Yes If yes	□ No		s) and address(es				
	□ No	ne name(s) and address(es		vhom he		d.
	□ No , please provide th	ne name(s) and address(es) of the doctor(s) v	vhom he	e/ she consulte	d.
	□ No , please provide th	ne name(s) and address(es) of the doctor(s) v	vhom he	e/ she consulte	d.
	□ No , please provide th	ne name(s) and address(es) of the doctor(s) v	vhom he	e/ she consulte	d.
	□ No , please provide th	ne name(s) and address(es) of the doctor(s) v	vhom he	e/ she consulte	d.
If yes	□ No , please provide th Name of Docto	ne name(s) and address(es) of the doctor(s) v	dress	e/ she consulte	d.
(c) Is the	□ No , please provide the Name of Doctor	r has suf	s) and address(es Name of Clinic/) of the doctor(s) v Hospital and Add er significant illnes	dress	e/ she consulted Dates of Con	d. sultat
(c) Is the	□ No , please provide the Name of Doctor	r has suf	s) and address(es Name of Clinic/	of the doctor(s) vertical and Added	whom he	e/ she consulted Dates of Con	d. sultat
(c) Is the	□ No , please provide the Name of Doctor patient suffering or please provide the	r has suf	s) and address(es Name of Clinic/	of the doctor(s) vertical and Added	whom he	Dates of Con	d. sultat
If yes	□ No , please provide the Name of Doctor patient suffering or please provide the	r has suf	s) and address(es Name of Clinic/	of the doctor(s) vertical and Added	whom he	Dates of Con	d. sultat
(c) Is the	□ No , please provide the Name of Doctor patient suffering or please provide the	r has suf	s) and address(es Name of Clinic/	of the doctor(s) vertical and Added	whom he	Dates of Con	d. sultat
(c) Is the	□ No , please provide the Name of Doctor patient suffering or please provide the	r has suf	s) and address(es Name of Clinic/	of the doctor(s) vertical and Added	whom he	Dates of Con	d. sultat

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

(d) Did you refer the patient to any other doctor	
If yes, please provide the name and addre	ess of the doctor(s).
(e) Please give any other information which yo	ou feel would be helpful in assessment of the patient's cla
lease enclose copies of specialist or hospital rep ne validity of the patient's claim.	orts together with any tests or similar evidence to suppor
to validity of the patient's claim.	
	- .
Signature of Doctor	Date
	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
Tel: 67371221 Website: www.manulife.com.sg