Manulife

ATTENDING PHYSICIAN'S STATEMENT (STILL BIRTH)

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:

Still Birth means the death of the foetus of the Life Insured of 28 weeks of pregnancy or older.

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

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

(c) What symptoms did the patient complain of when she first saw you for this condition?

____

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____

____

(d) According to the patient, how long has she been experiencing these symptoms?

____

____

(e) For how long do you think the patient has actually experienced these symptoms?

____

____

(f) What was the diagnosis?

____

____

____

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

(g) Date when the condition was first diagnosed: ________/ ________/ _________
dd mm yyyy

(h) 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.

____
____
____
____

(i) Please confirm the diagnosis of Still Birth as described above.

____
____
____

(j) Please state the duration of pregnancy: ____

(k) Please give full details of all investigations performed in relation to this condition and their results.

____
____
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____
____

(l) Please give the full details of the operation performed.

____
____
____
____

(m) Date of operation: ________/ ________/ _________
dd mm yyyy

(n) Please give the name and address of the doctor who has confirmed the diagnosis of Still Birth.

____
____
____
____

(o) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

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____
____
____

3. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

(i) Name of referral doctor: ____

(ii) Name of clinic/ hospital: ____

(iii) Date referred: ____

(b) Did the patient consult other doctors for this illness or its symptoms before she consulted you?

□ Yes □ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

(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) Are you the patient's regular doctor? □ Yes □ No

If yes, since when? ________/ ________/ __________
dd mm yyyy

If no, please provide the name and address of the patient's regular doctor.

____

____

(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

Address & Official Stamp

Name and Qualification (printed)

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