Manulife

# ATTENDING PHYSICIAN'S STATEMENT (MAJOR PLASTIC SURGERY DUE TO ACCIDENTS)

| 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:***

***Major plastic surgery due to accidents means the undergoing of re-constructive surgery (restoration or re-construction of the shape of and appearance of body structures which are defective, missing or damaged or misshapen) performed by a registered surgeon to correct body disfigurement caused by an Accident or Assault.***

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

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

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

(c) Date of accident: ________/ ________/ _________
dd mm yyyy

(d) Where did the accident occur?

______________________________________________________________________________________

______________________________________________________________________________________

(e) Please provide a brief description of the accident.

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______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

(f) Please give details of the circumstances leading to the injury.

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______________________________________________________________________________________

______________________________________________________________________________________

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Reg. No. 198002116D
Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424
Tel: 67371221 Website: www.manulife.com.sg

(g) Was the patient under the influence of alcohol at the time of accident? □ Yes □ No

If yes, please state the blood alcohol content: ________________________________

(h) In your opinion, were the injuries the result of the accident described above? □ Yes □ No

If yes, please state your reasons.

________________________________________________________________________________

(i) Was there reason to suspect that there were contributory circumstances which led to the injury?

□ Yes □ No

If yes, please state your reasons.

________________________________________________________________________________

________________________________________________________________________________

(j) Was surgery required for this condition? □ Yes □ No

(k) If yes, type of surgery performed: _______________________________________________________

(l) Please state the reason(s) for surgery.

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

(m) Please describe the part(s) of the body structures affected by surgery.

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

(n) Date of surgery: ________/ ________/ _________
dd mm yyyy

(o) Name and address of Hospital: __________________________________________________________

________________________________________________________________________________

(p) Name and address of the Doctor who performed the surgery.

________________________________________________________________________________

________________________________________________________________________________

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

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

(r) Please give details of the patient's history and present habits pertaining to alcohol consumption, cigarette smoking and drug addiction.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## 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 condition 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) Please provide us with any other additional information that will enable the Company to assess this 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**

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