

TOTAL & PERMANENT DISABILITY CLAIM - STATEMENT OF MEDICAL EXAMINER

SECTION B

- 1. Section B is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries sustained or illnesses diagnosed.
- 2. Completion of Section B must be done **six months** after the diagnosis date.
- 3. Expenses incurred to obtain this report will be borne by the Participant.

C/B	of Participant:irth Cert No/Passport No:					
Α	re you the Participant's regular doctor? Yes No If yes, since what date ?(dd/mm/yyyy) Date of <u>first</u> consultation for the current condition:(dd/mm/yyyy					
a.						
b.	. Date(s) of subsequent consultation	(s)				
	Date of consultation (dd/mm/yyyy)	Treatment gi	ven	Healing progress		
C.	Please state the symptoms presente	d and date symptoms <u>firs</u>	<u>t</u> appeared			
	Symptoms presented at fire	st consultation	Date symptoms first started (dd/mm/yyyy)			
- 1						
	i) What is the source of this information of the source of	·	-			
d.	If "Others", please specify the nam	e of the person and relation	onship to the Particip			
d.	If "Others", please specify the nam	e of the person and relation	onship to the Particip	ant.		
	If "Others", please specify the nam	e of the person and relation	onship to the Participa	ant.		
e.	If "Others", please specify the nam Diagnosis: Date of <u>first</u> diagnosis: Diagnosis was <u>first</u> made by (nam	e of the person and relation	onship to the Participa	ant.		
e. f.	If "Others", please specify the name Diagnosis: Date of <u>first</u> diagnosis: Diagnosis was <u>first</u> made by (name Date diagnosis was made known to What was the exact information co	e of the person and relation	onship to the Participa	(dd/mm/yyyy)(dd/mm/yyyy)		
e. f. g. h.	If "Others", please specify the name Diagnosis: Date of <u>first</u> diagnosis: Diagnosis was <u>first</u> made by (name Date diagnosis was made known to What was the exact information co	e of the person and relation e of doctor): the Participant: nveyed to the Participant?	onship to the Participa	(dd/mm/yyyy) (dd/mm/yyyy)		

С	. How does the Participant's disability prevent him from per	forming the above listed duties of his	/her occupation?		
а	. Is the condition a result of an accident? Yes No If yes, please state the date of accident: Describe in detail how the accident happened.	(dd/mm/yyyy) Time of accide	nt:(am/pm)		
b	. Was the accident reported to the police? ☐ Yes ☐ No If yes, please provide the name of the police division and				
С	(Please enclose a copy of the police report) Was the Participant under the influence of alcohol/drugs a	t the time of accident? □ Yes □ N			
d	. Is the condition self-inflicted? ☐ Yes ☐ No ☐ If yes, p	lease provide full details:			
е	. Type of treatment including any operations performed and	I his/her response.			
а	. Please describe fully the nature and severity of the Partici	pant's disabilities.			
b	. Is his /her disability progressing, stagnant or recovering?				
С		e state approximate date:	(dd/mm/yyyy)		
d	is the Participant able to perform all the 6 Activities of Daily Living (ADL) without assistance?				
-	Activities of Daily Living	Participant able			
-	Transfer	Yes	No		
-	Mobility	Yes	No		
-	Continence	Yes	No		
F	Dressing	Yes	No		
-	Bathing/Washing	Yes	No		
	Eating	Yes	No		

f. Does the patient suffer any loss of use of limbs or/and fingers?	Please i. Righ ii. Left g. Did the If yes, h. Did the Please i. Did the If yes, j. Please k. Is the I If yes, v I. If Partic Yes m. When	e state the ht Upper Lin t Upper Lin e patient su , please sta e patient su e give deta e patient su , please giv e give full d Participant when is he	power of patier mb: uffer amputation ated level of am uffer any loss of ills on Insured's uffer any loss of we details on Ins details with resp t able to perform e/she expected hable to return to	n of limbs or/and fingers? n putation seen (proximal, mide f eyes?	Right Lower Limb : Left Lower Limb : Yes □ No Ie, distal)	(ii) Left eye :
i. Right Upper Limb:	i. Righ ii. Left g. Did the If yes, h. Did the Please i. Did the If yes, j. Please k. Is the I If yes, v I. If Partic Yes m. When	nt Upper Lin t Upper Lin e patient su please sta e patient su e give deta e patient su please giv e give full d Participant when is he	mb: uffer amputation ated level of amuffer any loss of ails on Insured's uffer any loss of a details on Insured at able to perform e/she expected able to return to	n of limbs or/and fingers? Inputation seen (proximal, mide f eyes?	Left Lower Limb :	(ii) Left eye :b. (ii) Left ear :
ii. Left Upper Limb:	ii. Left g. Did the If yes, h. Did the Please i. Did the If yes, j. Please k. Is the I If yes, v I. If Partic □ Yes m. When	t Upper Lim e patient su , please sta e patient su e give deta e patient su e patient su e patient su e patient su Participant when is he	uffer amputation ated level of amuffer any loss of a lils on Insured's uffer any loss of the details on Insured at able to perform the level of the toreturn to the level of the lils with response to the level of t	n of limbs or/and fingers? Inputation seen (proximal, middle f eyes?	Left Lower Limb :	(ii) Left eye :b. (ii) Left ear :
g. Did the patient suffer amputation of limbs or/and fingers?	g. Did the If yes, h. Did the Please i. Did the If yes, j. Please	e patient su , please sta e patient su e give deta e patient su please giv e give full d Participant when is he cipant is un	affer amputation ated level of amuffer any loss of a miles on Insured's affer any loss of a details on Insured at able to perform able to return to a state of a mable to return to a state of	n of limbs or/and fingers? Inputation seen (proximal, middle feyes?	□ Yes □ No le, distal)	(ii) Left eye :b. (ii) Left ear :
If yes, please stated level of amputation seen (proximal, middle, distal)	If yes, h. Did the Please i. Did the If yes, j. Please	please state patient sure give detained patient sure patient sure please give full decrease. Participant when is he cipant is un	ated level of amulated level of amulated level of amulated level of amulated is on Insured's authors of the details on Insured is on Insured letails with respected anable to return to	nputation seen (proximal, middle feyes?	le, distal)dl l abilities and cognition er usual occupation?	(ii) Left eye :b (ii) Left ear :
Please give details on Insured's Visual Acuity; (i) Right eye:	h. Did the Please i. Did the If yes, j. Please k. Is the I If yes, v I. If Partic Yes m. When	e patient su e give deta e patient su please giv e give full d Participant when is he	uffer any loss of its on Insured's uffer any loss of the details on Insured its details with respected the details with respected the details to return to	f eyes?	dl I abilities and cognition er usual occupation? on?	(ii) Left eye :b (ii) Left ear :
Please give details on Insured's Visual Acuity; (i) Right eye:	Please i. Did the If yes, j. Please k. Is the I If yes, v I. If Partic	e give detale patient su please give full de participant when is he cipant is un	uffer any loss of the details with respected to perform e/she expected nable to return to	s Visual Acuity; (i) Right eye : of hearing?	diabilities and cognition er usual occupation?	b (ii) Left ear :
i. Did the patient suffer any loss of hearing?	i. Did the If yes, j. Please k. Is the I If yes, v I. If Partic Yes m. When	e patient su please give full description Participant when is he	uffer any loss of the details with respected to perform the label to return to the label to the label to return to the label to	of hearing?	diabilities and cognition er usual occupation?	b (ii) Left ear :
If yes, please give details on Insured's hearing, (i) Right ear:	If yes, j. Please k. Is the I If yes, v I. If Partic Yes m. When	please give full descriptions of the please give full descriptions. Participant when is he cipant is un	re details on Insidetails with responsible to perform e/she expected hable to return to	sured's hearing, (i) Right ear pect to the Participant's mental states of his/h to return to his usual occupat	abilities and cognition abilities and cognition er usual occupation?	n. □ Yes □ No(dd/mm/yyyy)
If yes, please give details on Insured's hearing, (i) Right ear:	If yes, j. Please k. Is the I If yes, v I. If Partic Yes m. When	please give full descriptions of the please give full descriptions. Participant when is he cipant is un	re details on Insidetails with responsible to perform e/she expected hable to return to	sured's hearing, (i) Right ear pect to the Participant's mental states of his/h to return to his usual occupat	abilities and cognition abilities and cognition er usual occupation?	n. □ Yes □ No(dd/mm/yyyy)
j. Please give full details with respect to the Participant's mental abilities and cognition. Recognition Perticipant Per	j. Pleasek. Is the I If yes, \(\text{If Partic} \) \text{\text{\$\sum Yes}} \text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\texi{\$\texi\\$\$\text{\$\text{\$\text{\$\text{\$\text{\$\texi\exitit{\$\text{\$\texi\\$\$\text{\$\text{	e give full d	t able to perform	nect to the Participant's menta	abilities and cognition and cognition er usual occupation?	n. □ Yes □ No(dd/mm/yyyy)
k. Is the Participant able to perform all the normal duties of his/her usual occupation?	k. Is the I If yes, v I. If Partic Yes m. When	Participant when is he	t able to perform	m all the normal duties of his/h	er usual occupation?	□ Yes □ No (dd/mm/yyyy)
k. Is the Participant able to perform all the normal duties of his/her usual occupation?	If yes, \\ I. If Partic ☐ Yes m. When	Participant when is he	t able to perform	m all the normal duties of his/h	er usual occupation?	□ Yes □ No (dd/mm/yyyy)
If yes, when is he/she expected to return to his usual occupation?	If yes, \ I. If Partic □ Yes m. When	when is he	e/she expected	to return to his usual occupat	on?	(dd/mm/yyyy)
a. Did the Participant consult other doctors for this condition or its symptoms BEFORE he/she consulted you? Yes No If yes, please give name(s) and address(es) of the doctor(s) whom he/she consulted. Name of Doctor Name of Clinic/Hospital and Address Date of First Consultation (dd/mm/yyyy) Date of First Diagnosis Name and Address of Attending Doctor Date of First Diagnosis Name and Address of Attending Doctor Date of Private Diagnosis Name and Address of Attending Doctor Date of Private Diagnosis Name and Address of Attending Doctor Date of Private Diagnosis Name and Address of Attending Doctor Date of Private Diagnosis Name and Address of Attending Doctor Date of Private Diagnosis Name and Address of Attending Doctor Date of Private Diagnosis Date of Priva			ıı yes, wn	nat type of occupation can he/		
Yes No If yes, please give name(s) and address(es) of the doctor(s) whom he/she consulted. Name of Doctor Name of Clinic/Hospital and Address Date of First Consultation (dd/mm/yyyy) b. Is the Participant suffering or has suffered from any other significant illnesses? Yes No If yes, please state.	a. Did the	ı is Particip	ant expected to	o engage in these occupations	?	(dd/mm/yyyy
Name of Doctor Name of Clinic/Hospital and Address Date of First Consultation (dd/mm/yyyy) b. Is the Participant suffering or has suffered from any other significant illnesses? Yes No If yes, please state. Date of First Diagnosis Name and Address of Attending Doctor		e Participa	int consult othe	r doctors for this condition or	ts symptoms BEFORE	he/she consulted you?
Name of Doctor Name of Clinic/Hospital and Address (dd/mm/yyyy) b. Is the Participant suffering or has suffered from any other significant illnesses? Yes No If yes, please state. Date of First Diagnosis Name and Address of Attending Doctor	☐ Yes	s 🗆 No	If yes, please	e give name(s) and address(es) of the doctor(s) whor	m he/she consulted.
☐ Yes ☐ No ☐ If yes, please state. Date of First Diagnosis Name and Address of Attending Doctor.		Name of E	Ooctor	Name of Clinic/Hosp	tal and Address	
☐ Yes ☐ No ☐ If yes, please state. Date of First Diagnosis						
☐ Yes ☐ No ☐ If yes, please state. Date of First Diagnosis Name and Address of Attending Doctor.						
☐ Yes ☐ No ☐ If yes, please state. Date of First Diagnosis Name and Address of Attending Doctor.						
Date of First Diagnosis Name and Address of Attending Doctor	b. Is the	Participan ¹		as suffered from any other sig	nificant illnesses?	
liness I Name and Address of Affending Loctor	□ Yes	•	t suffering or ha	_		
		•	· ·	ease state.		
		s 🗆 No	If yes, ple	Date of First Diagnosis	Name and	Address of Attending Doctor
		s 🗆 No	If yes, ple	Date of First Diagnosis	Name and	Address of Attending Doctor
		s 🗆 No	If yes, ple	Date of First Diagnosis	Name and	Address of Attending Doctor
		s 🗆 No	If yes, ple	Date of First Diagnosis	Name and	Address of Attending Doctor

	c. i. Is the Participant physically or mentally incapacitated from	ever continuing in any employment? Yes No
	ii. If yes, when did such disability commence?	(dd/mm/yyyy)
	d. Is the Participant terminally ill? ☐ Yes ☐ No	
7.	If the incapacity of the Participant cannot be confirmed upon exa	mination or ascertained at this moment, would you recommend a
	review of his/her condition in the near future? $\ \square$ Yes $\ \square$ No	
	If yes, what is the appropriate time period for the Company to re-	assess this claim?(dd/mm/yyyy)
8.	Please provide us with any other additional information that will e	nable the Company to assess this claim. Enclose copies of
	laboratory tests results, if any.	
DEC	CLARATION:	
true t	to the best of my knowledge and belief and that no material fact h	the undersigned, do hereby declare the foregoing answers are nas been concealed from the Company. Furthermore, I certify that nt and the facts as stated above represent my medical opinion o
	nature of the Attending Physician	Date (dd/mm/yyyy)
Nam	ne of the Attending Physician	Contact No.
Profe	essional Qualification	Official Stamp and Address