INDIVIDUAL DREAD DISEASE CLAIM FORM

Dear Claimant,

We are sorry to learn about your illness.

In order for us to process your claim, we require the following:

(1) Claimant's Statement
(2) Doctor's Statement (medical fee to be borne by Policyholder)
(3) Consent Form For Medical Report / Personal Information
(4) Histopathological / Biopsy Reports (for Cancer)
(5) ECG Reading & Enzymes Assays (for Heart Attack)
(6) CT Scan / MRI Scan Results (for Stroke)
(7) Available Laboratory and Test Results

Once we have received **all** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

Submission of Claim Documents

Please submit all claim documents:

(I) Through your servicing adviser; OR

(II) Personally or by post to the below address:

Customer Service Section
20 McCallum Street
#07-01 Tokio Marine Centre
Singapore 069046

INDIVIDUAL DREAD DISEASE CLAIM
CLAIMANT'S STATEMENT

IMPORTANT NOTES :
(1) The issue of this claim form is not an admission of liability.
(2) This claim form is to be completed by the Assured.
(3) Tokio Marine Life Insurance Singapore Ltd. ("**the Company**") reserves the right to request for additional medical reports when it deems necessary.

CLAIMANT'S STATEMENT : TO BE COMPLETED BY ASSURED

PART 1 : DETAILS OF POLICY(IES)

1.1 Policy No. : (a) ____________ (b) ____________

(c) ____________ (d) ____________

PART 2 : DETAILS OF ASSURED

2.1 Name : ____________

(as stated in NRIC / Passport)

2.2 NRIC No. / Passport No. : ____________

2.3 Residence Address : ____________

2.4 Occupation : ____________

PART 3 : DETAILS LIFE ASSURED [if different from Part (2)]

3.1 Name : ____________

(as stated in NRIC / Passport)

3.2 NRIC No. / Passport No. : ____________

3.3 Residence Address : ____________

3.4 Occupation : ____________

3.5 Contact No. : ____________ (H) ____________ (O) ____________ (HP)

PART 4 : DETAILS OF ILLNESS(ES) / MEDICAL CONDITION(S) OF LIFE ASSURED

4.1 Describe fully the symptoms experienced for which the Life Assured consulted a doctor :

____

4.2 When did the symptoms first appear before the Life Assured consulted a doctor? ____________

(dd/mm/yyyy)

4.3 Date when the Life Assured **FIRST** consulted a doctor for the above symptoms : ____________

(dd/mm/yyyy)

____________ ____________

Signature of Assured Date (dd/mm/yyyy)

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20 McCallum Street, #07-01 Tokio Marine Centre, Singapore 069046 Tel: 6592 6100 Fax: 6223 9120 www.tokiomarine-life.sg

4.4 If consultation was for illness, describe fully the nature and extent of the Life Assured’s Illness :

____

____

4.5 If consultation was due to an accident, describe fully the nature of the Life Assured’s injuries and how it happened :

____

____

4.6 Has the Life Assured previously suffered from or received treatment for a similar / related illness? ☐ Yes ☐ No
If **Yes**, please provide details :

____

____

PART 5 : DETAILS OF MEDICAL CONSULTATIONS / HOSPITALISATION

5.1 Please provide details of doctor(s) whom the Life Assured has consulted in connection to his/her illness :

Name of Doctor / Hospital	Address	Date of First Consultation / Hospitalisation

5.2 Please provide details of the Life Assured’s regular doctor(s), date and reason(s) of consultation :

Name of Doctor	Address	Date of Consultation	Reason(s) of Consultation

______________________ ______________________
Signature of Assured Date (dd/mm/yyyy)

PART 6 : OTHERS

6.1 Has any of the Life Assured's family members suffered from a similar / related illness? ☐ Yes ☐ No

Relationship	Nature of Illness	Date of Diagnosis (dd/mm/yyyy)

6.2 Does the Life Assured smoke cigarette? ☐ Yes ☐ No

If **Yes**, what is the Life Assured's daily consumption? ________ Sticks

How long has the Life Assured been smoking? ________ years ________ months

PART 7 : OTHER INSURANCES

7.1 Was the Life Assured insured with other insurance company(ies)? ☐ Yes ☐ No

If **Yes**, please provide the following details :

Name of Insurance Company	Date of Issue	Sum Assured	Type of Plan	Claim Amount	Claim Notified
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

*I / We declare that all answers given by *me / us in this form are, to the best of *my / our knowledge and belief, true and complete.

I hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd., any relevant information concerning the abovenamed Assured / Life Assured, and;

(b) Tokio Marine Life Insurance Singapore Ltd. to release to any medical source, insurance office, or organization, any relevant information concerning the abovenamed Assured / Life Assured, at any time.

A photocopy of this authorization shall have the same effect as the original.

____

Signature of Assured

Date : ________________________________

(dd/mm/yyyy)

Name(s) : ________________________________

NRIC No(s) : ________________________________

Address(es) : ________________________________

____

Contact No(s) : ____________ (H) ____________ (O) ____________ (HP)

Relationship to Life Assured : ________________________________

TOKIO MARINE

INDIVIDUAL DREAD DISEASE CLAIM
DOCTOR'S STATEMENT

1 Name of Patient (as stated in NRIC / Passport): ____________________

2 NRIC / Passport No. ____________________

INSTRUCTIONS: Please tick [√] in the appropriate box and complete the relevant sections in respect to the illness claimed. Please submit ONLY the relevant sections to us upon completion.

	Illness		Sections to be completed:
1.	Major Cancer	☐	1 & 14
2.	Stroke	☐	1 & 6
3.	Heart Attack	☐	1 & 2
4.	Coronary Artery By-pass Surgery	☐	1 & 12
5.	Kidney Failure	☐	1 & 5
6.	Alzheimer's Disease	☐	1 & 8
7.	Aplastic Anaemia	☐	1 & 24
8.	Bacterial Meningitis	☐	1 & 25
9.	Benign Brain Tumour	☐	1 & 23
10.	Blindness (Loss of Sight)	☐	1 & 7
11.	Coma	☐	1 & 11
12.	Deafness (Loss of Hearing)	☐	1 & 26
13.	End Stage Liver Disease	☐	1 & 22
14.	End Stage Lung Disease	☐	1 & 21
15.	HIV due to blood transfusion and occupationally acquired HIV	☐	1 & 9
16.	Encephalitis	☐	1 & 28
17.	Fulminant Hepatitis	☐	1 & 13
18.	Heart Valve Surgery	☐	1 & 3
19.	Terminal Illness	☐	1 & 31
20.	Loss of Speech	☐	1 & 17
21.	Major Burns	☐	1 & 20
22.	Major Organ Transplantation	☐	1 & 10
23.	Motor Neurone Disease	☐	1 & 27
24.	Multiple Sclerosis	☐	1 & 15
25.	Muscular Dystrophy	☐	1 & 19
26.	Paralysis (Loss of Use of Limbs)	☐	1 & 30
27.	Parkinson's Disease	☐	1 & 18
28.	Poliomyelitis	☐	1 & 4
29.	Primary Pulmonary Hypertension	☐	1 & 16
30.	Surgery to Aorta	☐	1 & 29
31.	Angioplasty & Other Invasive Treatment For Coronary Artery	☐	1 & 32

Please enclose copies of Histopathology / Biopsy Report (for Cancer), ECG Reading & Enzymes Assays (for Heart Attack), CT Scan / MRI Scan results (for Stroke and Benign Brain Tumour) and all laboratory and Test results, etc and any relevant hospital reports that are available.

SECTION 1 GENERAL INFORMATION

a. Are you the patient's regular doctor? ☐ Yes ☐ No

If **Yes**, since when : ____________________

If No, kindly provide the Name and Address of the patient's regular doctor (if known to you):

____

b Date of the patient's first consultation with you for this illness : ____________________

c Please state symptoms presented and date symptoms first appeared in the box provided below :

Symptoms Presented at First Consultation	Date symptoms first started (dd/mm/yyyy)

d In your opinion, how long do you think the illness / condition has existed? Please provide reasons.

____

____

Hospital / Clinic Stamp

Date (dd/mm/yyyy) ____________________

Signature of Attending Doctor

Name and Address

Qualification

CLM/DRD/0114/01

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e Please provide full and exact details of the diagnosis and its clinical basis.

____

____

f What is the date of diagnosis? ____________________

g What is the date when diagnosis was first made known to the patient? ____________________

h Has the patient previously suffered from the condition described above or any related illness? ☐ Yes ☐ No

If Yes, kindly provide the details below:

Illness	Date of First Diagnosis (dd/mm/yyyy)	Name and Address of Attending Doctor

i Did the patient consult other doctors for this illness or its symptoms BEFORE he / she consulted you? ☐ Yes ☐ No

If Yes, kindly provide the details below:

Name of Doctor	Name of Clinic / Hospital and Address

j Is there anything in the patient's personal medical history which would have increased the risk of the above illness? If yes, please give full details including the date of diagnosis and name and address of attending doctor. ☐ Yes ☐ No

____

____

k Is there anything in the patient's family history which would have increased the risk of this illness? ☐ Yes ☐ No

If yes, please provide details.

____

____

l Is the patient suffering from other significant illness(es) / condition(s)? ☐ Yes ☐ No

If **Yes**, kindly provide the details below :

Illness / Condition	Date of First Consultation	Name of Hospital / Doctor	Address

m Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

____

____

n Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information.

____

____

____

Hospital / Clinic Stamp	Signature of Attending Doctor
Date (dd/mm/yyyy) ____________________	Name and Address Qualification

SECTION 2 HEART ATTACK

a i. Date of Attack: ______________________

ii. Was there a current history of chest pain and/or shortness of breath? ☐ Yes ☐ No

iii. Were there any changes in the ECG indicative of a myocardial infarction? ☐ Yes ☐ No

iv. Was there a serial elevation of cardiac enzymes documented? ☐ Yes ☐ No

v. Was there death of a portion of the heart muscle? ☐ Yes ☐ No

vi. Was there elevation of Troponin (T or I) documented? ☐ Yes ☐ No
If yes, please state the date of test and its reading.

____

vii. Was left ventricular ejection fraction taken 3 months or more after the event? ☐ Yes ☐ No
If yes, please state the date it was done and its percentage:

____

viii. Date of return to normal activities: ______________________

SECTION 3 HEART VALVE SURGERY

a i What is the date of onset of the heart valve defects? ______________

ii. Was open heart surgery performed? ☐ Yes ☐ No
If yes, please state the surgical procedure used to correct the valvular problem.

____

iii. What is the date of the surgery? ______________

SECTION 4 POLIOMYELITIS

a i. What was the cause of the disease?

____

ii. What is the current condition of the patient and what is the prognosis?

____

iii. Was there paralysis of the limb muscles or respiratory muscles for at least 3 months? ☐ Yes ☐ No

SECTION 5 KIDNEY FAILURE

a i. Has the patient's renal disease reached end-stage? ☐ Yes ☐ No

ii. Is there chronic renal failure of both kidneys? ☐ Yes ☐ No

iii. Is the renal failure reversible? ☐ Yes ☐ No

iv. Is the patient undergoing regular peritoneal dialysis or haemodialysis? ☐ Yes ☐ No

If yes, what was the date of commencement? ______________

v. Has renal transplantation been performed? ☐ Yes ☐ No

If yes, when was it done? ______________

vi. Was the patient a recipient of the renal transplant? ☐ Yes ☐ No

vii. Is the renal dialysis / transplantation required as a life-saving procedure? ☐ Yes ☐ No

______________________ ______________________

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd/mm/yyyy) ______________ | Name and Address
Qualification

SECTION 6 STROKE

a i. What is the date of initial episode? ______

ii. What is the nature of the episode?

______

______

iii. What is the duration of acute symptoms? ______

iv. Is the patient able to resume normal activities? ☐ Yes ☐ No

If Yes, please state when: ______

If No, please state the patient's latest physical and mental limitation (with date of latest assessment):

Date (dd/mm/yyyy)	Neurological Deficits

v. When is the date of the patient's next review with you? ______

b i. Was there any neurological deficit 6 weeks after the date of diagnosis of patient's stroke? ☐ Yes ☐ No

If yes, please provide details:

______

ii. Are these neurological deficits likely to be permanent? ☐ Yes ☐ No

iii. Has there been an infarction of brain tissue, haemorrhage or embolisation from an extracranial source? ☐ Yes ☐ No

iv. Are the investigations or findings consistent with the diagnosis of a new stroke? ☐ Yes ☐ No

If Yes, please provide details:

______

v. Is this a Transient Ischaemic Attack? ☐ Yes ☐ No

vi. Is the brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease? ☐ Yes ☐ No

vii. Is the patient's illness a vascular disease affecting the eye or optic nerve? ☐ Yes ☐ No

viii. Is the patient's condition a result of ischaemic disorders of the vestibular system? ☐ Yes ☐ No

SECTION 7 BLINDNESS (LOSS OF SIGHT)

a i What was the date of onset? ______

ii What is the current visual acuity of both eyes?

Left eye: ______ Right eye: ______

iii. What forms of treatment were rendered?

______

iv. What is the prognosis?

______

v. Will further surgery improve his / her sight? ☐ Yes ☐ No

If yes, what kind of surgery will be necessary?

______

______

______ Hospital / Clinic Stamp

Date (dd/mm/yyyy) ______

______ Signature of Attending Doctor

Name and Address

Qualification

SECTION 8 ALZHEIMER'S DISEASE

a i. Is there evidence of deterioration or loss of intellectual capacity? ☐ Yes ☐ No

ii. Is there abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of patient? If yes, please describe the findings: ☐ Yes ☐ No

iii. Did the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric illness or drug / alcohol related organic disorder? If yes, please provide the details: ☐ Yes ☐ No

SECTION 9 HIV DUE TO BLOOD TRANSFUSION & OCCUPATIONALLY ACQUIRED HIV

a i. Was the infection due to blood transfusion? ☐ Yes ☐ No

ii. Was the blood transfusion medically necessary or given as part of medical treatment? ☐ Yes ☐ No

iii. Was the blood transfusion received in Singapore? ☐ Yes ☐ No
If yes, when was the transfusion done?

iv. Was the infection resulted from any other means including sexual activity and the use of intravenous drugs? If yes, please state the likely cause: ☐ Yes ☐ No

v. Is the source of infection established from the institution that provided the blood transfusion? ☐ Yes ☐ No

vi. Is the Institution able to trace the origin of the HIV tainted blood? ☐ Yes ☐ No

b. Is the patient suffering from Thalassaemia Major or Haemophilia? ☐ Yes ☐ No

c. Is the occupation of the patient a medical practitioner, houseman, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in Singapore? ☐ Yes ☐ No
If yes, please state the actual occupation:

i. Was there an accident whilst the patient was carrying out the normal professional duties of his occupation in Singapore? ☐ Yes ☐ No
If yes, please state the date of accident:

ii. Was the accident involved a definite source of the HIV infected fluids? ☐ Yes ☐ No

iii. Was an HIV antibody test done before the accident occur? ☐ Yes ☐ No
If yes, what was the result?

iv. Was an HIV antibody test done after the accident had occurred? ☐ Yes ☐ No
If yes, what was the result?

SECTION 10 MAJOR ORGAN TRANSPLANTATION

a i Which of the organ is involved?

ii What is the date of operation?

iii. What is the prognosis?

iv. Was the transplant resulted from an irreversible end stage failure of the relevant organ? ☐ Yes ☐ No

Hospital / Clinic Stamp

Date (dd/mm/yyyy)

Signature of Attending Doctor
Name and Address
Qualification

SECTION 11 COMA

a i. What was the date of onset? ______________

ii. Is there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for at least 96 hours? ☐ Yes ☐ No

iii. Was there brain damage resulting in permanent neurological deficit? ☐ Yes ☐ No

iv. Has the sequelae lasted more than 30 days from the onset of the coma? ☐ Yes ☐ No

b What was the cause of coma?

____

SECTION 12 CORONARY ARTERY BY-PASS SURGERY

a i. Which arteries are involved and what is the degree of narrowing (%) in respect of each involved artery?

____

____

ii. Was coronary arteriography performed? ☐ Yes ☐ No

iii. Was open heart surgery performed? ☐ Yes ☐ No
If yes, please state the number and sites of graft inserted.

____

iv. What is the date of the surgery? ______________

v. Please provide the name of surgeon who perform the surgery and the name & address of hospital where the surgery was performed.

____

vi. What other forms of treatment were rendered?

____

vii. Has the patient previously suffered from the above illness or any other cardiovascular disease? ☐ Yes ☐ No
If yes, please provide the details:

____

SECTION 13 FULMINANT HEPATITIS

a i. Please provide full and exact details of the diagnosis including the viru(s) involved.

____

ii. What is the approximate date of onset? ______________

iii. Is there a rapidly decreasing liver size? ☐ Yes ☐ No

iv. Is there a submassive to massive necrosis of the liver? ☐ Yes ☐ No

v. Is there a rapidly deterioration of liver function? ☐ Yes ☐ No

vi. Was there deepening jaundice? ☐ Yes ☐ No

vii. Was there hepatic encephalopathy? ☐ Yes ☐ No

b What is the current condition of the patient and what is the prognosis?

____

____

______________________________ ______________________________

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd/mm/yyyy) ______________ | Name and Address
Qualification

TOKIO MARINE

SECTION 14 MAJOR CANCERS

i. What was the site or organ involved and the precise histology of the tumour?

____

ii. Is biopsy of the tumour performed? ☐ Yes ☐ No

iii. What is the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TMN classification etc)

____

iv. Is the disease completely localized? ☐ Yes ☐ No

v. Was there invasion of adjacent tissues? ☐ Yes ☐ No

vi. Were regional lymph nodes involved? ☐ Yes ☐ No

vii. Were there distant metastases? ☐ Yes ☐ No

viii. Please provide full details of all treatment provided (e.g. surgery, chemotherapy, radiotherapy etc).

____

____

ix. If the diagnosis is leukaemia, please provide details of the actual type.

____

____

x. If the diagnosis is malignant melanoma, please provide full details of size, thickness (Breslow classification) and / or depth of invasion (Clark level).

____

____

xi. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

If yes, please provide the date of diagnosis for HIV / AIDS: ______________________________

SECTION 15 MULTIPLE SCLEROSIS

a i. Is there a history of repeated relapse and remission or a steady progressive disability? ☐ Yes ☐ No

ii. Are there lesions producing well-defined neurological deficits involving the optic nerves, brain stem and spinal cord which occurred over a continuous period of at least 6 months? ☐ Yes ☐ No

iii. Are there signs and symptoms of multiple lesions? ☐ Yes ☐ No

iv. Was the neurological damages caused by SLE or HIV / AIDS? ☐ Yes ☐ No
If yes, what was the cause?

____

b Has the patient returned to normal activities? ☐ Yes ☐ No

If yes, please provide the date. ______________________________

c What are the patient's present limitations, physical and mental?

____

____

______________________________	______________________________
Hospital / Clinic Stamp	Signature of Attending Doctor
Date (dd/mm/yyyy) ______________________	Name and Address
	Qualification

SECTION 16 PRIMARY PULMONARY HYPERTENSION

a i. Was there a dyspnoea and fatigue? ☐ Yes ☐ No

ii. Was there increase in left atrial pressure of at least 20 units or more? ☐ Yes ☐ No

iii. Was there pulmonary resistance of at least 3 units above normal? ☐ Yes ☐ No

iv. Was there pulmonary artery pressure of at least 40mmHg? ☐ Yes ☐ No

v. Was there pulmonary wedge pressure of at least 6mmHg? ☐ Yes ☐ No

vi. Was there right ventricular end-diastolic pressure of at least 8 mmHg? ☐ Yes ☐ No

vii. Was there right ventricular hypertrophy, dilation and signs of right heart failure and decompensation? ☐ Yes ☐ No

b Was the patient able to engage in any physical activity without discomfort? ☐ Yes ☐ No

c Are the symptoms present even at rest? ☐ Yes ☐ No

d i. Was there permanent physical impairment of at least class IV of the NYHA classification of cardiac impairment? ☐ Yes ☐ No

ii. If not, what is the NYHA classification of the current condition?

____

e In your medical opinion, what was the cause of the pulmonary arterial hypertension?

____

SECTION 17 LOSS OF SPEECH

a i What is the date of onset? ____________

ii. Is the loss of speech considered total and irrecoverable? ☐ Yes ☐ No

iii. Has the inability to speak established for a continuous period of 12 months? ☐ Yes ☐ No

iv. Were there any associated neurological or psychiatric conditions contributing to the patient's loss of speech? If yes, please provide details. ☐ Yes ☐ No

____

b What was the cause of the loss of speech?

____

SECTION 18 PARKINSON'S DISEASE

a i. What is the cause of the disease?

____

b Is the patient able to perform (whether aided or unaided) for a continuous period of at least 6 months the followings:

i. Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means ☐ Yes ☐ No

ii. Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances ☐ Yes ☐ No

iii. Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No

iv. Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene ☐ Yes ☐ No

v. Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

vi. Ability to feed oneself once food has been prepared and made available ☐ Yes ☐ No

______________________________ ______________________________

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd/mm/yyyy) ____________ | Name and Address

Qualification

SECTION 19 MUSCULAR DYSTROPHY

a i. Is there any evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex? If yes, please describe the findings: ☐ Yes ☐ No

ii. Which are the muscles involved?

b i. Was the diagnosis confirmed by an electromyogram? ☐ Yes ☐ No

ii. Was the diagnosis confirmed by muscle biopsy? ☐ Yes ☐ No

c Is the patient able to perform (whether aided or unaided) for a continuous period of at least 6 months the followings:

i. Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means ☐ Yes ☐ No

ii. Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances ☐ Yes ☐ No

iii. Ability to move from a bed to an upright chair or wheelchair and vice versa ☐ Yes ☐ No

iv. Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene ☐ Yes ☐ No

v. Ability to move indoors from room to room on level surfaces ☐ Yes ☐ No

vi. Ability to feed oneself once food has been prepared and made available ☐ Yes ☐ No

SECTION 20 MAJOR BURNS

a i. What is the date of onset? ____________

ii. Please state the areas affected, the percentage of surface area and the degree of burns in each affected area:

Area Affected	Percentage of surface area	Degree of burns

iii. Were the Third Degree (full thickness of the skin) burns covering at least 20% of the surface of the patient's body? ☐ Yes ☐ No

b i. Where and how did the accident happen resulting in the major burns?

ii. Are the burns self-inflicted? ☐ Yes ☐ No
If yes, please provide details.

SECTION 21 END STAGE LUNG DISEASE

a i. Has the patient's lung disease reached end-stage? ☐ Yes ☐ No
If yes, please state the exact date: ____________

ii. What is the FEV1 of the patient?

iii. Is the patient undergoing extensive and permanent oxygen therapy for hypoxemia? ☐ Yes ☐ No

iv. What is the Arterial blood gas analyses (PaO_2) of the patient?

Hospital / Clinic Stamp

Date (dd/mm/yyyy) ____________

Signature of Attending Doctor

Name and Address

Qualification

SECTION 22 END STAGE LIVER DISEASE

a i. Is there end stage liver failure? ☐ Yes ☐ No

If yes, what is the date which end stage liver failure was diagnosed? ____________

ii. Is there evidence of permanent jaundice? ☐ Yes ☐ No

iii. Is there evidence of ascites? ☐ Yes ☐ No

iv. Is there evidence of hepatic encephalopathy? ☐ Yes ☐ No

b. What was the cause of the liver failure?

____

c Was the liver disease secondary to alcohol or drug abuse? ☐ Yes ☐ No
If yes, please provide details:

____

d What is the current condition of the patient and what is the prognosis?

____

____

SECTION 23 BENIGN BRAIN TUMOUR

a i. Please provide the detailed location of the tumour.

____

ii. Is the tumour life threatening? ☐ Yes ☐ No

iii. Has the tumour caused damage to the brain? ☐ Yes ☐ No
If yes, please provide details.

____

iv. Has the patient undergone surgical removal? ☐ Yes ☐ No

v. If the surgical removal is not performed, has the tumour caused permanent neurological deficit? ☐ Yes ☐ No
If yes, please provide details of the deficits.

____

vi. Is the patient's condition a cyst, granuloma, vascular malformation or haematoma? ☐ Yes ☐ No

vii. Is the patient's tumour in the pituitary gland or spinal cord? ☐ Yes ☐ No

viii. Is the tumour confirmed by imaging studies such as CT scan or MRI? ☐ Yes ☐ No

SECTION 24 APLASTIC ANAEMIA

a i. What Is the haemoglobin level, red cell count, white cell count and platelet count?

____

b What is the nature of treatment?

i. Blood product transfusion ☐ Yes ☐ No

ii. Marrow stimulating agents ☐ Yes ☐ No

iii. Immunosuppressive agents ☐ Yes ☐ No

iv. Bone marrow transplantation ☐ Yes ☐ No

____________ ____________

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd/mm/yyyy) ____________ | Name and Address

Qualification

SECTION 25 BACTERIAL MENINGITIS

a i. Was the diagnosis confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture? ☐ Yes ☐ No

ii. Has the patient returned to normal activities? ☐ Yes ☐ No
If yes, please provide the date. ______________________

iii. What are the patient's present limitations, physical and mental?
____

iv. Were there any neurological deficit which has lasted for at least 6 weeks? ☐ Yes ☐ No

v. Are these neurological deficits likely to be permanent? ☐ Yes ☐ No
If yes, please provide details of the deficits.
____

vi. Was the condition present due to HIV / AIDS infections? ☐ Yes ☐ No

SECTION 26 DEAFNESS (LOSS OF HEARING)

a i What was the date of onset? ____________

ii. Was the diagnosis confirmed by an audiometric and sound-threshold? ☐ Yes ☐ No

iii. Is the loss of hearing considered irreversible? ☐ Yes ☐ No

iv. Is there a loss of at least 80 decibels in all frequencies of hearing? ☐ Yes ☐ No

b What was the cause of loss of hearing?
____

SECTION 27 MOTOR NEURONE DISEASE

a i. Is there progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis? If yes, please provide details. ☐ Yes ☐ No
____

ii. Please provide details of the extent of neurological deficits.
____

iii. Are the neurological deficits likely to be permanent? ☐ Yes ☐ No

SECTION 28 ENCEPHALITIS

a i. Has the patient returned to normal activities? ☐ Yes ☐ No
If yes, please provide the date. ______________________

ii. What are the patient's present limitations, physical and mental?
____

iii. Was there any significant and serious permanent neurological deficit? ☐ Yes ☐ No
If yes, please provide details of the deficit.
____

iv. Are the permanent neurological deficits documented for at least 6 weeks? ☐ Yes ☐ No
If yes, please provide details.
____

v. Was the condition present due to HIV / AIDS infections? ☐ Yes ☐ No

______________________ ______________________

Hospital / Clinic Stamp — Signature of Attending Doctor

Date (dd/mm/yyyy) ______________________ — Name and Address

Qualification

SECTION 29 SURGERY TO AORTA

a i. What was the type of surgery performed?

______

ii. When was the surgery performed? ______

iii. Was excision and surgical replacement of the diseased aorta with a graft performed? ☐ Yes ☐ No

iv. Was the surgery performed using minimally invasion or intra arterial techniques? ☐ Yes ☐ No

SECTION 30 PARALYSIS (LOSS OF USE OF LIMBS)

a i. When was the date of onset? ______

ii. Please state the number and limbs involved?

______

b Is there total and irreversible loss of use of at least 2 entire limbs? ☐ Yes ☐ No

c Was the paralysis caused by self-inflicted injuries? ☐ Yes ☐ No
If not, please provide details on the cause:

______

SECTION 31 TERMINAL ILLNESS

a i. What was the diagnosis?

______

ii. What is the prognosis of the illness?

______

iii. What is the nature of treatment?

______

iv. In your opinion, is the condition highly likely to lead to death within 12 months? ☐ Yes ☐ No
If yes, please provide your basis.

______

v. Is the condition present as a result of HIV / AIDS? ☐ Yes ☐ No

SECTION 32 ANGIOPLASTY & OTHER INVASIVE TREATMENT FOR CORONARY ARTERY

a i. Which coronary arteries are involved and what is the degree of narrowing (%) in respect of each involved artery?

______

______

ii. Please state the name of procedure performed.

______

iii. Please state the date of the procedure performed. ______

iv. Please confirm whether the procedure was medically necessary. ☐ Yes ☐ No

______ ______

Hospital / Clinic Stamp | Signature of Attending Doctor

Date (dd/mm/yyyy) ______

Name and Address
Qualification

CONSENT FORM FOR MEDICAL REPORT / PERSONAL INFORMATION

NAME OF PATIENT : ______________________________

NRIC NO. : ______________ POLICY NO. : ______________

This consent form is required for an insurance claim.

I hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd., any relevant information concerning the abovenamed patient, and;

(b) Tokio Marine Life Insurance Singapore Ltd. to release to any medical source, insurance office, or organization, any relevant information concerning the abovenamed patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

____

Signature of *Patient / Patient's Parent / Next-Of-Kin

Name : ______________________________

Address : ______________________________

____

Relationship to Patient : ______________ NRIC No. : ______________

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