Great Eastern Life

Total And Permanent Disability Benefit Claim Form

(Medical Certification - to be completed by the attending doctor)

1.Patient Name : Policy Numbers :	2. NRIC (Old & New): Please verify the NRIC to ensure the identity of the patient
To be completed if disability was caused by an accident	
3. Date of Accident: Time : am/pm Where? Nature of Accident:	4. What were the extent of the injuries?
5. When did you first consult the patient?	6.Was the patient under influence of drug/alcohol?
To be completed if disability was caused by illness	
7.What was the symptoms / signs / complaints and when did they first appear?	8.What was the diagnosis and how was the diagnosis arrived at? What tests were carried out?
9. When was the diagnosis made and when was it made known to the patient?	10.How long had he/she been suffering from the illness or its related conditions?
11. What treatment or further management is the patient currently under?	
This Section Must Be Fully Completed	
12. Have you any knowledge of the patient suffering from other illness or related conditions. Please specify the illness or condition and when was it diagnosed.	

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13. Have you ever treated the patient for other illness or related conditions? If yes please give details:

Date	Diagnosis	Treatments

14. From your patient's records, whom did the patient see for treatments (regardless of what illness) prior to the onset of such disability.

Name & Address	Dates	Complaints	Treatments

15.Was she/he a referral case. Please provide the details of the referral doctor (name and address).	16.Is the patient undergoing any form of rehabilitation. What are the chances of recovery?
17.Are you anticipating any physiological condition that would permanently affect him/her to resume employment.	18. Any further information,clinical or otherwise which will assist us in assessing the claim.
19. When did you first treat the patient? And when was the last consultation date?	20. What is the expected recovery in the next 12 months?
21.In your opinion, could the patient resume any work for which he/she is reasonably fitted by education, training and experience.	22. Please describe any activities or functions that the patient should be restricted or prohibited from, due to his/her disability, if undertaken would endanger others.

23. Please describe the physical and cognitive functions which are totally loss as a result of his/her disability.

, Recovered ☐ Improved ☐ No improvement ☐ Deteriorating ☐

24. How would you assess the patient's degree of limitation in performing the following activities:

	Not Limited	Mildly Limited	-- Moderately Limited	Severly Limited	Incapable
Seeing/Vision	☐	☐	☐	☐	☐
Hearing/Sound	☐	☐	☐	☐	☐
Reasoning/Thinking/ Mental Faculty	☐	☐	☐	☐	☐
Lifting & carrying	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Changing posture	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Working with both hands	☐	☐	☐	☐	☐
Squating	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Using the lavatory	☐	☐	☐	☐	☐
Reach above shoulders	☐	☐	☐	☐	☐
Walk on uneven surface	☐	☐	☐	☐	☐
Inability to move in/out of chair	☐	☐	☐	☐	☐
.....	☐	☐	☐	☐	☐
.....	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

25. Patient can use hand for repetitive action:

	Right hand			
Simple grasping	Yes ☐	No ☐	Yes ☐	No ☐
Fine manipulating	Yes ☐	No ☐	Yes ☐	No ☐
Forearm rotation/movement	Yes ☐	No ☐	Yes ☐	No ☐
Power grip	Yes ☐	No ☐	Yes ☐	No ☐
Pushing / Pulling	Yes ☐	No ☐	Yes ☐	No ☐
_____	Yes ☐	No ☐	Yes ☐	No ☐
_____	Yes ☐	No ☐	Yes ☐	No ☐
_____	Yes ☐	No ☐	Yes ☐	No ☐

Signature of the Medical Officer-in- Charge

Name:

Tel No:

Official Stamp&address

Date: