ESSENTIAL CHILD CLAIM - DOCTOR'S STATEMENT

Note: This form is to be completed at the Patient's expense by the Attending Doctor.

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender ☐ Male ☐ Female

The claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

	Sections to be completed:		Sections to be completed:
☐	Severe Epilepsy — A, B & L	☐	Severe Asthma — A, G & L
☐	Glomerulonephritis with Nephrotic Syndrome — A, C & L	☐	Insulin-Dependent Diabetes Mellitus — A, H & L
☐	Rheumatic Fever with Valvular Impairment — A, D & L	☐	Intellectual Impairment due to Illnesses or Accident — A, I & L
☐	Severe Juvenile Rheumatoid Arthritis — A, E & L	☐	Leukaemia — A, J & L
☐	Kawasaki Disease with Heart Complications — A, F & L	☐	Severe Haemophilia A and B — A, K & L

Note: Assessment of claims and provision of benefits will be based on the Policy mentioned in this form.

SECTION A : Medical Record of the Patient

1. Are you the patient's usual Medical Attendant?

☐ YES ☐ NO

2. Over what period do your records extend?

i) First consultation ☐ Day ☐ Month ☐ Year

ii) Last consultation ☐ Day ☐ Month ☐ Year

3. What were the symptoms presented when you first attended the patient? How long has the patient been experiencing the symptoms when you first saw the patient?

Symptom(s)	Duration of Symptom(s)

4. Please describe the full and exact diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

ḍHas the patient previously suffered from the condition specified above or any possible related illness?

☐ YES ☐ NO

If Yes, please provide the full and exact details of diagnosis.

Diagnosis Date (DD/MM/YYYY)	Diagnosis

c. Is the condition above related directly or indirectly to any congenital/inherited disorders?

☐ YES ☐ NO

If Yes, please provide details.

7. Was the HIV test done?

☐ YES ☐ NO

If Yes, please provide dates and results of all HIV antibody tests done and enclose copy(s) of relevant laboratory reports.

Date (DD/MM/YYYY)	Test Result

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8. Does the patient have any personal history of any other medical or psychiatric condition?

☐ YES ☐ NO

If Yes, please provide details as per below

Nature of Condition	Date of Onset (DD/MM/YYYY)	Treatment Received	Current Status of the Condition

9. Please provide details of names, addresses and qualifications of all doctors, hospitals or clinics the patient has been referred or attended to for this condition.

Name	Qualification	Address of Doctor / Clinic / Hospital

SECTION B ▪ Severe Epilepsy

1. Please provide details of the diagnosis of Severe Epilepsy.

2. Has the patient experienced unprovoked Tonic-Clonic or Grand Mal seizures?

☐ YES ☐ NO

If Yes, please list down the dates and duration of all attacks in last 12 months.
Please enclose copy(s) of EEG report demonstrating the seizure attack(s).

3. Is there any known underlying cause of the seizure/epilepsy?

☐ YES ☐ NO

If Yes, please provide the details.

4. Has the patient undergone neurosurgery for treatment of epileptic seizure?

☐ YES ☐ NO

If Yes, please provide details of the surgery.

Date (DD/MM/YYYY)	Details of Surgery

5. Is the patient taking prescribed anti-epileptic (anti-convulsant) medications?

☐ YES ☐ NO

If Yes, please provide the details below

Name of Medication	Date of First Prescribed (DD/MM/YYYY)	Dosage Prescribed	Duration of Medication Taken

6. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

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Customer Service Tel (603) 2771 0228

SECTION C ▪ Glomerulonephritis with Nephrotic Syndrome

1. ***Please enclose copies of reports of the relevant laboratory (i.e. Blood and urine) tests done (e.g. FBC, RFT, Inflammatory markers).***

2. Please describe the treatment regimen prescribed to the patient.

Treatment Prescribed	Period of Treatment Prescribed	Purpose of the Treatment Prescribed

3. Has the patient been following the course of treatment as per above?

☐ YES ☐ NO

If No, kindly elaborate further.

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION D ▪ Rheumatic Fever with Valvular Impairment

1. Please tick [✓] the relevant options on the Revised Jones criteria.

- ☐ Carditis
- ☐ Arthritis (Mono/Poly)
- ☐ Chorea
- ☐ Erythema Marginatum
- ☐ Subcutaneous Nodule
- ☐ Fever (i.e. >38^{o}c)
- ☐ Raised Inflammatory markers (E.g. ESR / CRP)

2. Please provide details with supporting evidence of any streptococcus infection.

3. Is there any heart valve(s) defect resulting from the Rheumatic Fever?

☐ YES ☐ NO

If Yes, please state valve(s) involved with details of incompetence.

Please enclose copy(s) of quantitative investigation (i.e. echocardiogram) on the impaired heart valve function.

Heart Valve(s)	Degree of Defect(s)

4. Please provide details of the cause of the heart valve(s) defects.

5. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION E ▪ Severe Juvenile Rheumatoid Arthritis

1. Please provide the values of the listed component in the blood tests as per below.
   Please enclose copies of the relevant blood tests (e.g. Rheumatoid Factor, Inflammatory markers, FBC) done.

i)	Rheumatoid Factor	
ii)	Inflammatory Marker (Please specify which markers)	

2. Is there any widespread joint destruction AND major clinical deformity seen at the joints listed below? Please enclose copy(s) of the relevant imaging(s) done which demonstrating the joints destruction.

☐ YES ☐ NO

If Yes, please provide the details;

i)	Hands	
ii)	Wrists	
iii)	Elbows	
iv)	Hips	
v)	Ankles	
vi)	Cervical Spine	
vii)	Metatarsophalangeal joints	

3. Did the symptoms mentioned in Q2 persisted for at least 1 year?

☐ YES ☐ NO

If Yes, please state for how long.

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION F ▪ Kawasaki Disease with Heart Complications

1. Please provide the details of the Kawasaki Disease.

2. Was the abnormality on the cardiac involvement manifested by dilation or aneurism formation in the coronary arteries?

☐ YES ☐ NO

If Yes, please provide details as per below.

Please enclose ALL copies of echocardiogram done and any other investigations performed confirming this.

Date of Onset (DD/MM/YYYY)	Details

3. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION G ▪ **Severe Asthma**

1. Please provide details of the symptoms stated in Q3 (of Section A) as per listed below:

i) The Onset of the symptoms

☐ ACUTE ☐ CHRONIC

ii) Was the patient admitted to the hospital?

☐ YES ☐ NO

iii) Placed on mechanical ventilation in order to control the asthma attack?

☐ YES ☐ NO

If Yes, please details in the corresponding table.

Date of Admissions (DD/MM/YYYY)	Name of Address of Hospital(s)	Period (Hours) on Mechanical Ventilation	Was the period continuos? (Y/N)

2. Does the patient exhibit Harrison's Sulcus chest deformity resulting from the asthma?

☐ YES ☐ NO

3. Has the patient demonstrated significant growth impairment (defined as a height below 3rd percentile for child's age & sex with asthma) from previously normal height (above 5th percentile) from at least 1 year old?

☐ YES ☐ NO

If Yes, please provide details as per below.

Please enclose copies of the Child Health Booklet which displaying the growth chart from at least 1 year old to the current age.

Date of Recording (DD/MM/YYYY)	Height (cm)	Weight (kg)

4. Was the Pulmonary Function Test (Peak Expiratory Flow Rate) done?

☐ YES ☐ NO

If Yes, provide details of all recordings of the patient's peak expiratory flow rate below.
The recording must be made on at least 4 occasions at interval of no less than 1 month in a period of at least 12 months.

Kindly to enclose copies of the patient's Peak Flow Chart which displaying at least 4 trials within 12 months period

Date of Recording (DD/MM/YYYY)	Maximum Peak Expiratory Flow Rate	Predicted rate for a child of the same age, sex & build?	Type of Treatment Prescribed?

5. Was the patient prescribed with continuous daily use of (oral) corticosteroid to control the symptoms?

☐ YES ☐ NO

If Yes, please state for how long the patient has been on the medication.

6. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION H ▪ Insulin-Dependent Diabetes Mellitus

1. Please provide the details of the diagnosis as listed below:

i) Fasting Blood Glucose _____ mmol/L

ii) OGTT (Oral Glucose Tolerance Test) _____ mmol/L

iii) HBA1c _____ mmol/mol

Please enclose copies of the relevant laboratory (i.e. Blood) tests done demonstrating the diagnosis of Insulin- Dependent Diabetes Mellitus.

2. Was the patient on exogenous insulin?

☐ YES ☐ NO

If Yes, please state for how long the patient has been depending on the insulin.

3. Please provide details of the insulin injection regime.

Type of Insulin	Dosage (Units/mL)	Frequency (per day)	Site(s) of Injections

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION I ▪ Intellectual Impairment due to Illnesses or Accident

1. Please attach copy(s) of the Child Health Care Booklet displaying the routine check-up from birth to the current ones.

2. Was the impairment due to illness or accident? Kindly provide the following details according to the option selected.

☐ ILLNESS (please specify)

☐ ACCIDENT

i) Date of Accident ____ Day ____ Month ____ Year

ii) Nature of Accident

iii) Injuries Sustained

iv) Hospitalization Details

Date of Admission (DD/MM/YYYY)	Name of Hospital(s)	Treatment(s) Received

☐ OTHERS (please specify)

3. Is there any current PERMANENT neurological impairment resulting from Q2?

☐ YES ☐ NO

If Yes, please provide the following details.

i) Type of Impairment

ii) Details on how the diagnosis was made

4. Date when the patient and/or the patient's guardian or parent(s) first became aware of the condition(s).

____ Day ____ Month ____ Year

5. Was the IQ test/related tests done on the patient?

☐ Yes ☐ No

If Yes, please provide the following details. ***Kindly Please enclose copies of investigations performed confirming this.***

Date (DD/MM/YYYY)	Name of the Test(s) Done	Result(s)

6. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION J ▪ Leukaemia

1. Was the Bone Marrow Trephine Biopsy AND Aspiration done?

☐ YES ☐ NO

If Yes, ***please attach the histopathology report(s).***

If No, please provide reason(s)

2. Was there any imaging(s) done?

☐ YES ☐ NO

If Yes, ***specify and attach all of the imaging report(s).***

3. What was the nature of the treatment?

☐ Chemotherapy
☐ Radiotherapy
☐ Others (Please provide details of the treatment(s)

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION K ▪ Severe Haemophilia A and B

1. Please select the relevant type of the Haemophilia.

☐ Severe Haemophilia A ☐ Severe Haemophilia B

2. Please provide the following details of the diagnosis.

Please enclose copies of the relevant laboratory (i.e. Blood) tests (i.e. Factor Assays, Clotting profile) done

Factor(s) Level _____ IU/dL

Normal (Reference) Range _____ IU/dL

3. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please give details.

SECTION L : Attending Doctor's Declaration

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR
☐ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Hospital/ Doctor :

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