WELLNESS AND FERTILITY CARE BENEFIT - DOCTOR'S STATEMENT

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

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Other

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:
☐	Depressive Disorder	A, B & G
☐	Anxiety Disorder	A, C & G
☐	Dermatologist Visit due to Severe Acne Diagnosis	A, D & G
☐	Fertility Care Benefit (For Male)	A, E & G
☐	Fertility Care Benefit (For Female)	A, F & G

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

SECTION A : Medical History of the Patient

1. Are you the patient's regular/family doctor?
   ☐ YES ☐ NO

   If yes, over what period do your records extend?
   ☐ Day ☐ Month ☐ Year

2. Date the patient first consulted you for this illness / injury.
   ☐ Day ☐ Month ☐ Year

3. The presenting signs and symptoms.

4. The date when the patient first noticed the presenting signs and symptoms.
   ☐ Day ☐ Month ☐ Year

5. In your opinion, how long have the presenting signs and symptoms lasted prior to the first consultation with you?
   ☐ Day ☐ Month ☐ Year

SECTION B : Depressive Disorders

1. Type of depressive disorder the patient is diagnosed with: (Please tick [√] in the appropriate box)
   - ☐ Disruptive mood dysregulation disorder
   - ☐ Major depressive disorder
   - ☐ Persistent depressive disorder
   - ☐ Premenstrual dysphoric disorder
   - ☐ Depressive disorder due to another medical condition
   - ☐ Others. Please specify: _____

2. Is patient's depression disorder induced by substance/medication?
   ☐ Yes ☐ No

SECTION C : Anxiety Disorder

1. Type of anxiety disorder the patient is diagnosed with: (Please tick [√] in the appropriate box)
   - ☐ Generalized anxiety disorder
   - ☐ Specific phobia
   - ☐ Social anxiety disorder
   - ☐ Separation anxiety disorder
   - ☐ Agoraphobia
   - ☐ Panic disorder
   - ☐ Others. Please specify: _____

2. Is patient's anxiety disorder induced by substance/medication?
   ☐ Yes ☐ No

SECTION D : Dermatologist Visit due to Severe Acne Diagnosis

1. Is patient on oral antibiotic therapy?
   ☐ Yes ☐ No

2a. If yes, kindly provide the following.

Drug name of oral antibiotic therapy : _____

2b. Date of patient start oral antibiotic therapy.
☐ Day ☐ Month ☐ Year

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2c. Duration of antibiotic prescribed.

☐ Day ☐ Month ☐ Year

3. Please advise Life Assured's severity according to the Comprehensive Acne Severity Scale (CASS) (Please tick in the appropriate box)

☐ Grade 0 (clear): No lesions to barely noticeable ones; very few scattered comedones and papules.
☐ Grade 1 (almost clear): Hardly visible from 2.5 metres away; a few scattered comedones, few small papules and very few pustules.
☐ Grade 2 (mild): Easily recognisable; less than half of the affected area is involved; many comedones, papules and pustules.
☐ Grade 3 (moderate): More than half of the affected area is involved; numerous comedones, papules and pustules.
☐ Grade 4 (severe): Entire area is involved; covered with comedones, numerous pustules and papules, a few nodules and cyst.
☐ Grade 5 (very severe): Highly inflammatory acne covering the affected area, with nodules and cyst present.

SECTION E : Fertility Care Benefit (For Male)

1. Was patient diagnosed with any of the following illnesses? (Please tick [√] in the appropriate box)

Male Cancer for any of the following sites:

☐ Breast
☐ Prostate
☐ Testicle
☐ Scrotum
☐ Penis

Male Carcinoma-In-Situ and Early Prostate Cancer for any of the following sites:

☐ Breast Carcinoma-In-Situ
☐ Prostate Carcinoma-In-Situ
☐ Testicle Carcinoma-In-Situ
☐ Scrotum Carcinoma-In-Situ
☐ Penis Carcinoma-In-Situ
☐ Early Prostate Cancer

2. Is patient planning to undergo chemotherapy or radiotherapy as medical treatment?

☐ Yes ☐ No

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3. Is patient's infertility associated with one of the following? (Please tick [√] in the appropriate box)
   - ☐ Azoospermia (no measurable sperm in the ejaculate)
   - ☐ Oligospermia (low sperm count)
   - ☐ Teratospermia (high abnormal sperm morphology/ shape)
   - ☐ Asthenospermia (reduced sperm motility/ movement)
   - ☐ Ejaculatory duct obstruction

4. Type of fertility treatment rendered. (Please tick [√] in the appropriate box)
   - ☐ Sperm Cryopreservation
   - ☐ Intrauterine Insemination (IUI) Treatment
   - ☐ In-Vitro Fertilization (IVF)

5. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.

SECTION F : Fertility Care Benefit (For Female)

1. Was patient diagnosed with any of the following illnesses? (Please tick [√] in the appropriate box)
   Female Cancer for any of the following sites:
   - ☐ Breast
   - ☐ Cervix Uteri
   - ☐ Fallopian Tube
   - ☐ Ovary
   - ☐ Uterus
   - ☐ Vagina/Vulva

   Female Carcinoma-In-Situ for any of the following sites:
   - ☐ Breast
   - ☐ Cervix Uteri
   - ☐ Fallopian Tube
   - ☐ Ovary
   - ☐ Uterus
   - ☐ Vagina/Vulva

2. Is patient planning to undergo chemotherapy or radiotherapy as medical treatment?
   ☐ Yes ☐ No

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3. Is patient's infertility associated with one of the following? (Please tick [√] in the appropriate box)

- ☐ Endometriosis
- ☐ Diethylstilbestrol (DES) Exposure
- ☐ Blocked or surgically removed fallopian tubes that are not the result of voluntary sterilization
- ☐ Polycystic ovarian syndrome (PCOS). Kindly provide the following information / supporting document(s) (whichever is relevant):
  - (i) Total or free testosterone level: _____ nmol/L
  - (ii) Androgen level: _____ nmol/L
  - (iii) Clinical manifestations of elevated androgen levels: (Please tick [√] in the appropriate)
    - ☐ Hirsutism
    - ☐ Acne
    - ☐ Alopecia
  - (iv) Menstrual cycle: _____ days apart or _____ cycles per year
  - (v) Ultrasound finding: Morphology of Polycystic Ovary
    Number of Follicles per Ovary : _____
    Ovarian Volume : _____

4. Type of fertility treatment rendered. (Please tick [√] in the appropriate box)

- ☐ Oocyte Cryopreservation
- ☐ Intrauterine Insemination (IUI) Treatment
- ☐ In-Vitro Fertilization (IVF)

5. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.

SECTION G : 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 / Clinic :