Sompo Insurance Singapore Pte. Ltd.
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Singapore Land Tower, Singapore 048623
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Co. Reg. No.: 198905490E | GST Reg. No.: M200903196

Medical Certificate of Treatment Form

This form is to be completed by the Claimant's Medical Attendant whose replies should be as full as possible. No claim can be admitted unless a medical certificate is furnished at the expense of the claimant.

Medical Information Authority **Policy / Certificate No** _____

I hereby authorize any hospital surgeon, medical practitioner or clinic or other person who has attended to me or examined me with respect to the below mentioned injury or sickness, to disclose to **Sompo Insurance Singapore Pte. Ltd.** any and all information with respect to the injury or illness and, to provide to **Sompo Insurance Singapore Pte. Ltd.** copies of all hospital or medical records, including prior medical history.

_____ _____
Employer's Signature/Company's Stamp/Date Claimant's/Employee's Signature/Date

_____ _____
Name Name

1. **Name of Patient:** _____
2. **Name of Employee / Member's Company:** _____
3. **Name of Medical Establishment:** _____
4. **Nature of Admission:** Out-patient ☐ In-patient ☐ Day Surgery ☐
5. **Period of Admission:** From _____ To _____

6. **Diagnosis of illness or extent of injury:**

_____
_____
_____
_____
_____

7. **Please specify the date of first diagnosis.**

_____

8. **When did you inform the patient of your diagnosis?**

_____

9. **Is patient aware of having this condition prior to seeing you?** Yes ☐ No ☐

10. **When did patient first consult you for the symptoms?**

_____

11. **According to patient, when did he/she first notice symptoms of condition prior to seeing any doctor?**

_____

12. How long do you feel the symptoms/illness/injury have been existing prior to consulting you?

_____

13. Was patient referred by any doctor to seeing you? Yes □ No □

If yes, please state name and address of referring doctor.

_____

_____

14. What is the cause of illness or injury?

_____

_____

_____

_____

15. Is the condition due to pregnancy, infertility, childbirth, abortion? Yes □ No □

If yes, please specify the condition and the approximate date of commencement.

_____

_____

_____

Approximate date of commencement _____

16. Is condition a congenital anomaly or a physical defect present at birth? Yes □ No □

17. Is condition a nervous or mental disorder? Yes □ No□

18. Is condition a result of self-destruction or intentional self-inflicted injury? Yes □ No □

19. Has any permanent disability been suffered Yes □ No □

If yes, please state nature and percentage of disability suffered.

_____

_____

_____

20. Any possibility of having a relapse? Yes □ No □

21. Has patient previously seen any other doctor for symptoms or been treated for same or similar condition?

Yes □ No □ Not to my knowledge □

If yes, please state when and describe. Please indicate the name and address of any consulting doctor.

_____

_____

_____

22. Based on normal medically accepted pathological development of the condition, would there have existed symptoms or manifestations of the condition prior to the insured's first consultation with you?

Yes ☐ No ☐

_____

_____

23. Describe surgical procedures or treatment rendered (include name and dosage if medication was given).

_____

_____

_____

_____

24. Date surgical procedures or treatment was rendered : _____

25. Name of Surgeon : _____

26. Is surgery for cosmetic reason? **Yes** ☐ **No** ☐

27. Is surgery medically necessary? **Yes** ☐ **No** ☐

28. Is patient still under your care for this condition? **Yes** ☐ **No** ☐

If no, give date your service terminated : _____

_____ _____

Signature of Doctor/Surgeon Name and Address of Clinic/Hospital (with chop)

_____ _____

Name and Title Date

Please forward this form to **Sompo Insurance Singapore Pte. Ltd.**
Claims Department
50 Raffles Place
#03-03 Singapore Land Tower
Singapore 048623