

# Tenet Insurance Company Ltd

(A wholly owned company of Hwa Hong Corporation Limited)  
11 Collyer Quay #09-00 The Arcade Singapore 049317 Tel: 6221 2211 Fax: 6221 3302  
Company Registration No. 195700067Z <http://www.tenetinsurance.com>



## MEDICAL CERTIFICATE OF TREATMENT

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 **Tenet Insurance Company Ltd** any and all information with respect to the injury or illness and, to provide to **Tenet Insurance Company 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 see 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.

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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

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

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24. Date surgical procedures or treatment was rendered.

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25. Name of Surgeon.

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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.

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\_\_\_\_\_  
Signature of Doctor/Surgeon

\_\_\_\_\_  
Name and Address of Clinic/Hospital (with chop)

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
Date

Please forward this form to

**Tenet Insurance Company Ltd**  
Claim Department  
11 Collyer Quay  
#09-00, The Arcade  
Singapore 049317