







11. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

Name of Doctor	Name of Clinic/Hospital	Address

**C. MEDICAL HISTORY**

12. Has the patient previously suffered from Lung Disease or any related illnesses?  Yes  No

If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. \_\_\_\_\_

Date of Consultation	Name and Address of Doctor	Diagnosis

13. Is there anything in the patient's medical history which would have increased the risk of Lung Disease?

Yes  No

If yes, please provide details including the date of consultations, their resulting diagnosis, name and address of attending doctor. Please state source of information. \_\_\_\_\_

Date of Consultation	Name / Address of Doctor	Diagnosis

14. Please give details of the patient's family history which would have increased the risk of having Lung Disease (including the relationship, nature of illness, date of diagnosis) Please state source of information. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day. Please state source of information. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

17. Does the patient have or ever had any other significant health condition(s)?  Yes  No

If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending doctor. Please state source of information. \_\_\_\_\_

Date of Consultation	Name / Address of Doctor	Diagnosis

**D. ADDITIONAL INFORMATION**

18. Please provide us with any other additional information that will enable the Company to assess this claim.

\_\_\_\_\_  
\_\_\_\_\_

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**I hereby certify that the above statements are true and complete to the best of my knowledge and belief.**

\_\_\_\_\_  
**Name of Attending Physician (Please print)**

\_\_\_\_\_  
**Degree/Specialty**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**PRC Number / PTR Number**

\_\_\_\_\_  
**Telephone Number (s)**

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**To the Attending Physician :** You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.