

12. Please provide details of **ALL** investigations/test performed and attach copies of results of any investigations performed. e.g. resting ECGs, exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

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

Date of Consultation	Name of Doctor	Name of Clinic/Hospital/Address

C. MEDICAL HISTORY

14. Has the patient previously suffered from any related illnesses? Yes No

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

Date of Consultation	Name of Doctor / Address	Diagnosis

15. Is there anything in the patient's medical history which would have increased the risk of Major Organ Transplantation? Yes No

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

Date of Consultation	Name of Doctor / Address	Diagnosis

16. Please provide details of the patient's family history, which would increase the risk of Major Organ Transplantation (including the relationship, nature of illness, date of diagnosis). Please state source of information. _____

17. Please provide 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. _____

18. Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. _____

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

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

Name of Doctor	Name of Clinic/ Hospital and Address

D. ADDITIONAL INFORMATION

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

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

Signature Over Printed Name of Physician

Date Signed

Qualification

Address

PRC Number / PTR Number

Telephone Number (s)

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.