

(a) Is the progressive degenerative disorder affecting the following?

- Motor neurons of the cerebral cortex.
- Widespread weakness on an upper motor neuron basis
- Progressive spastic weakness of the limbs
- Preceded or followed by spastic dysarthria and dysphagia
- Combined involvement of the corticospinal and corticobulbar tracts

8. Please comment on whether the diagnosis was supported by Electromyogram (EMG).

9. Please provide full details of current treatment provided.

10. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g. resting ECGs, ultrasound, surgical reports, X-rays, MRI / CT scans, neurological reports and any other imaging studies, laboratory evidence etc., and other relevant hospital reports.

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 the condition specified above or any related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints? Yes No

If yes, please provide details.

13. Is there anything in the patient's medical history which would have increased the risk of Primary Lateral Sclerosis?

Yes No

If yes, please give dates of consultations, the resulting diagnosis, the 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 Primary Lateral Sclerosis (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 and 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 and source of information.

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

If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

D. ADDITIONAL INFORMATION

18. 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.

Name of Attending Physician (Please print)

Degree/Specialty

Signature

Date Signed

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.