

(c) Is the diagnosis supported by imaging evidence of multiple medullary cysts with cortical atrophy?

Yes No

If yes, please provide details.

(d) Is the patient required to undergo regular peritoneal dialysis or hemodialysis? Yes No

If yes, please state type of dialysis, date of first dialysis and frequency.

8. (a) Has kidney transplantation been performed? Yes No

If yes, when was it done and by whom? (Please state name and address)

If no, has surgery been planned or is the patient on the waiting list for kidney transplant? Please provide details.

(b) What is the prognosis of the patient and the treatment plan?

9. Please provide details of all investigations/test performed and attach copies of all hospital surgical procedures including cystoscopy report, histological, radiological reports (X-rays, pyelogram etc.), laboratory reports and other relevant hospital reports.

10. 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

11. Has the patient previously suffered from Renal 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

12. Is there anything in the patient's medical history which would have increased the risk of Medullary Cystic 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

13. Please give details of the patient's family history which would have increased the risk of having Medullary Cystic Disease (including the relationship, nature of illness, date of diagnosis).

Please state source of information. _____

14. 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. _____

15. 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. _____

16. 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. _____

Date of Consultation	Name / Address of Doctor	Diagnosis

D. ADDITIONAL INFORMATION

17. 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.