

## ATTENDING PHYSICIAN'S STATEMENT MAJOR DISEASE/CRITICAL ILLNESS PARKINSON'S DISEASE

Pat	ient's Name					
Att	ending Physician's Name		Address			
Thi	s section must be completed by a qualified an	nd registered phy	sician at the ex	xpense of t	he claimant.	
bee	e above name is insured with us against the happen submitted in connection with <b>PARKINSON'S</b> peration in the completion of this form.	pening of certain of DISEASE. To e	contingent event nable us to ass	s associated ess the clai	d with his/her he m, we would be	ealth. A claim has e grateful for your
Α.	GENERAL INFORMATION					
1.	Are you the patient's usual medical doctor?		Yes	□ N	lo	
	If yes, over what period do your records extend	to?				
	Start date / / //	уууу	End date _	//	mm	_/
2.	When did the patient first consult you for this co	ndition?	_	//	mm	
3.	Please state symptoms presented and date sym	nptoms first appea	ared.	uu	111111	уууу
	Symptoms Presented at First Consultation		Date Symp	toms First	Started (DD/MN	M/YYYY)
	What / Who is the source of this information? _					
4.	In your opinion what were the likely durations of	the patient's sym	nptoms? Please	provide reas	sons.	
5.	Did the patient consult any other doctors for the If yes, please provide details below.	se symptoms befo	ore he/she cons	ulted you?	Yes	☐ No
	Name of Doctor		Name of Clin	ic/ Hospita	l and Address	



## B. DETAILS OF MAJOR DISEASE / CRITICAL ILNESS

	What is the diagnosis? Please provide		e diagnosis.				
(b)	Date of diagnosis	//	mm	/	у		
(c)	Please provide full and exact details of	of the disease or	condition ca			e.	
(d)	Please provide the name and address	s of doctor and cl	nic/hospital	where the d	iagnosis was	first made	
	Name of Doctor		Nam	e of Clinic/	Hospital an	d Address	;
(e)	Date when patient was first made awa	are of the diagnos	sis?	//	mm	/	ууу
Plea	ase provide details, including dates, of	the extent of the	patient's deg	jenerative di	seases of the	e central ne	ervous syster
ls th	e degenerative disease resulted from	loss of pigment c	ontaining ne	urons of the	brain?	Yes	☐ No
le th	ere unequivocal diagnosis of Parkinso	n's Disease by a	consultant n	eurologist?		Yes	☐ No
10 (11	es, please provide full details and name						

11. Is there presence of the following condition?



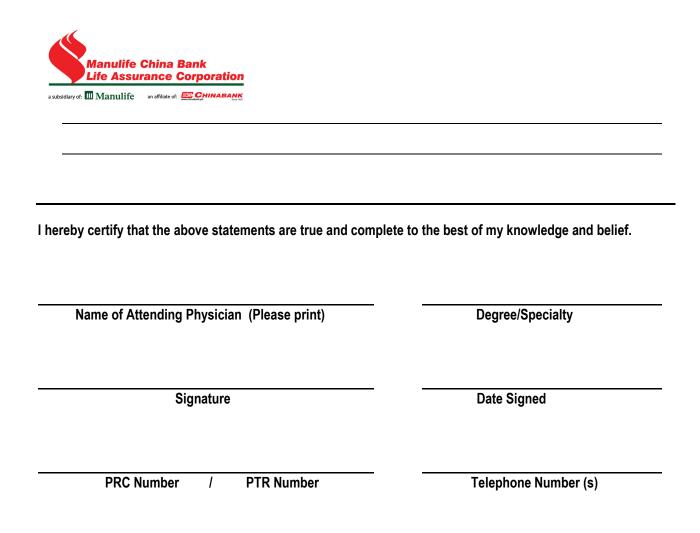
	i.	Cannot be controlled with medication.		Yes	☐ No
	ii.	Shows signs of progressive impairment.		Yes	☐ No
	iii.	There is permanent inability to perform without assi the six Activities of Daily Living	stance three of	Yes	☐ No
		If yes, please provide full details of the permanent Activities of Daily Living.	inability to perform, v	vithout assistan	ce, at least three of the si
		Capabilities (What the patient can do)			
		Limitations (What the patient cannot do	)		
12.	Is the Pa	rkinson's Disease considered idiopathic?	☐ Yes	☐ No	
13.	i. Druģ ii. Tox	rkinson's Disease resulted from any of the following? g induced Yes [ ic causes Yes [ ease provide details.	No No		
14.	Please p	rovide full details of current treatment provided.			
15.	resting E	rovide details of all investigations/test performed ar ECGs, ultrasound, surgical reports, X-rays, MRI / y evidence etc., and other relevant hospital reports.			
16.		rovide the names and addresses of all clinics/hospit together with the names of the doctors consulted.	als to which the patie	nt has been refe	erred to or attended for thi
		Name of Doctor	Name of (	Clinic/Hospital	Address



MEDICAL HISTORY					
Has the patient previously suffered fr If yes, please provide details.	om the condition specif	ied above or any related illn	ess?	□ No	
Is there anything in the patient's medical history which would have increased the risk of Parkinson's Disease?  Yes No  If yes, please give date of consultations, the resulting diagnosis, the name and address of attending doctor. Please sta					
			ess of attending doctor.	Please sta	
Date of Consultation			Diagnosis	Please sta	
source of information.	Name / Add	Iress of Doctor	Diagnosis  having Parkinson's Dise	ase (includi	

## D. ADDITIONAL INFORMATION

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



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.

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