





10. Is the diagnosis of muscular dystrophy unequivocal and made by a consultant neurologist?  Yes  No

If yes, please provide full details and name of the consultant neurologist.

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11. Is the diagnosis supported by appropriate neuromuscular testing such as Electromyogram (EMG)?  Yes  No

If yes, please provide full details of the result and attach a copy.

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12. Did the condition result in permanent inability to perform, without assistance, at least three of the six Activities of Daily Living?

Yes  No

**Capabilities (What the patient can do)**

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**Limitations (What the patient cannot do)**

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13. What is the prognosis of the patient and treatment plan?

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14. Please provide full details of current treatment provided.

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15. Has surgical procedure been performed?  Yes  No

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16. 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.

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17. 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**

18. Has the patient previously suffered from the condition specified above or any related illness?  Yes  No

If yes, please provide details.

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19. Is there anything in the patient's medical history which would have increased the risk of Muscular Dystrophy?

Yes  No

If yes, please give date 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

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

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21. 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.

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**D. ADDITIONAL INFORMATION**

22. 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.**

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

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**Degree/Specialty**

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**Signature**

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**Date Signed**

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**PRC Number / PTR Number**

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**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.