







|                     |  |  |
|---------------------|--|--|
| <b>Consultation</b> |  |  |
|                     |  |  |
|                     |  |  |
|                     |  |  |

**C. MEDICAL HISTORY**

Has the patient previously suffered from Heart Valve Disease or any related illnesses?  Yes  No

If yes, please provide dates of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information. \_\_\_\_\_

| <b>Date of Consultation</b> | <b>Name of Doctor / Address</b> | <b>Diagnosis</b> |
|-----------------------------|---------------------------------|------------------|
|                             |                                 |                  |
|                             |                                 |                  |
|                             |                                 |                  |

15. Is there anything in the patient's medical history which would have increased the risk of Heart Valve Disease?

Yes  No

If yes, please provide full details including the date of diagnosis, name and address of attending doctor. Please state source of information. \_\_\_\_\_

| <b>Date of Consultation</b> | <b>Name of Doctor / Address</b> | <b>Diagnosis</b> |
|-----------------------------|---------------------------------|------------------|
|                             |                                 |                  |
|                             |                                 |                  |
|                             |                                 |                  |

16. Please provide details of the patient's family history, which would increased the risk of Heart Valve Disease (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 | Date of Consultation/Diagnosis |
|----------------|--------------------------------------|--------------------------------|
|                |                                      |                                |
|                |                                      |                                |
|                |                                      |                                |

**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.