

B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

6. (a) What is the diagnosis? Please provide full details of the diagnosis. _____

(b) Date of diagnosis _____ / _____ / _____
 dd mm yyyy

(c) Please provide any other details of the injury, disease or condition causing coma, including the date of and time of onset.

(d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/ Hospital and Address

(e) Date when patient was first made aware of the diagnosis? _____ / _____ / _____
 dd mm yyyy

(f) Was the patient admitted in the hospital? Yes No

If yes, please state name & address of hospital _____

Complaint/s _____

Date of Admission _____ Time _____ Date of Discharge _____ Time _____
 Admitted Discharged

7. Please describe the extent of the Coma.

(a) Date of onset _____ / _____ / _____
 dd mm yyyy

(b) How many hours was patient in a state of coma, with no response to external stimuli or internal needs?

(c) Was there no response to external stimuli for at least 96 hours? Yes No

(d) Does the patient require life support measures to sustain life? Yes No

If yes, please give details of the life support measures.

(e) Was there any brain damage resulting in a permanent neurological deficit 30 days after the onset of the Coma?

Yes No

If yes, please give details of the life support measures.

8. Please provide full details of tests and results which have been performed to establish the diagnosis of Coma, and attach copies of all relevant hospital reports, laboratory and test results, including neurological reports, CT scans, MRI and other imaging studies and surgical reports.

9. Please provide details of treatment administered.

10. Please provide the date and time of emergence from the state of no response to external stimuli.

Date Time

11. What is the current condition of the patient?

12. What is the prognosis?

13. Was the Coma resulting directly from alcohol or drug abuse? Yes No

If yes, please provide full details.

14. Was the Coma a result of a self-inflicted act? Yes No

If yes, please provide full details.

15. 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 doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

C. MEDICAL HISTORY

16. Has the patient previously suffered from any related illnesses / condition that caused the Coma? 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 of Doctor / Address	Diagnosis

17. Is there anything in the patient's medical history which would have increased the risk of Coma?

Yes No

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

Date of Consultation	Name of Doctor / Address	Diagnosis

18. Please give details of the patient's family history which would have increased the risk of Coma (including the relationship, nature of illness, date of diagnosis) Please state source of information. _____

19. 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.

20. 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.

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.

D. ADDITIONAL INFORMATION

22. 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.