

3. (a) What was the type of surgery performed?

(b) Surgery was performed to repair or correct:

- (i) Aneurysm YES / NO*
- (ii) Narrowing YES / NO*
- (iii) Dissection of the Aorta YES / NO*

(c) Was surgery performed by surgical opening of the chest or abdomen? YES / NO*

(d) Was surgery performed on the the thoracic or abdominal aorta and not its branches? YES / NO*

(e) Was surgery performed using any minimally invasive or intra-arterial technique? YES / NO*

(f) Name and address of doctor who performed the surgery.

(g) Hospital where the surgery was performed.

(h) Date of surgery:

Day	Month	Year

(i) If surgery was not performed, please state degree of aortic aneurysm or dissection. Please attach a copy of tests results.

(j) Where did the aneurysm or dissection occur?

Date

Signature of Doctor

This section is applicable to abdominal or thoracic aortic aneurysm or dissection (not its branches) conditions only.

4. (a) Please tick the condition which the Life Assured suffered from:

- Abdominal Aortic Aneurysm
- Abdominal Aortic Dissection
- Thoracic Aortic Aneurysm
- Thoracic Aortic Dissection

(b) Date of FIRST diagnosis of abdominal or thoracic aneurysm or dissection:

Day		Month		Year	

(c) Details leading to the diagnosis of the abdominal or thoracic aortic aneurysm or dissection.

(d) Diameter of the abdominal or thoracic aortic aneurysm or dissection (in millimeter). Please include a copy of the investigation report.

5. (a) Have you previously treated the Life Assured for any risk factors or related illnesses, e.g hypertension, angina, other vascular disease or endocarditis? YES / NO*

If "YES", please provide the following:

Medical Condition	Date of 1st diagnosis	Name of Doctor	Name and Address of the clinic/ hospital

Date

Signature of Doctor

- (b) Is there anything in the Life Assured's personal medical history and family history which would have increased the risk of abdominal or thoracic aortic aneurysm or dissection? YES / NO*
If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

- (c) Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of information.

- (d) Is the Life Assured suffering from any other significant illnesses? YES / NO*
If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

6. (a) Please describe the Life Assured's mental and cognitive abilities.

- (b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

7. (a) Did the Life Assured consult any other doctor for this illness of its symptoms BEFORE he/she consulted you? YES / NO*
If "YES", please give name(s) and address(es) of the doctor(s) whom he/she consulted.

Name of Doctor	Name of Clinic / Hospital and Address

- (b) Please provide the names and address of any hospital or clinic to which the Life Assured was referred and the names of the consultants attended.

Date

Signature of Doctor

8. Please state and attach copies of all relevant hospital report, laboratory and test results related to this illness.

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

Date

Signature & Official Stamp of Doctor