

3. (a) Please provide the full and exact details of the diagnosis.

(b) Date when illness was FIRST diagnosed:

Day	Month	Year

(c) Diagnosis was first made by (name of doctor): _____

(d) Date when the Life Assured first became aware of the condition:

Day	Month	Year

(e) Date when the Life Assured's PARENT first became aware of the condition:

Day	Month	Year

4. Was there excessive accumulation of cerebrospinal fluid within the cerebral ventricles? YES / NO*
If "YES", did the excessive accumulation of cerebrospinal fluid within the cerebral ventricles necessitate the insertion of an extra-cranial shunt? YES / NO*

5. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory/investigation results.

6. Has the Life Assured previously suffered from the condition specified above or any related illness? YES / NO*
If "YES", please give details including dates of consultations and the resulting diagnosis.

7. Did the Life Assured consult other doctors for this illness or 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

Date

Signature of Doctor

8. Please provide dates and results of all HIV and antibody tests done. Please also attach copies of all relevant laboratory reports.

9. Does the Life Assured have any personal history of any other major medical or psychiatric condition? YES / NO*
If "YES", please give details including nature of condition, date of onset, treatment received and current status of the condition.

10. Does the Life Assured have any family history of any major medical condition? YES / NO*
If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

11. Please provide any other information which may be of assistance to us in assessing this claim.

Date

Signature & Official Stamp of Doctor