

* Please delete where appropriate

[illegible]

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

1. Are you the Life Assured's usual medical doctor? YES/NO*

If "YES", since what date?

Day		Month		Year			

2. (a) Date when Life Assured first consulted you for Multiple Sclerosis:

Day		Month		Year			

(b) Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (D/M/Y)

What is the source of information?

Patient / Referring Doctor / Others*

If "Others", please specify:

(c) Please provide full and exact diagnosis of Life Assured's condition.

(d) Date when illness/condition was FIRST diagnosed:

Day	Month	Year

(e) Diagnosis was first made by (name of doctor) :

(f) Date when Life Assured first became aware of the illness :

Day		Month		Year			

Date _____

Signature of Doctor



3. (a) Please provide details, including dates, of the extent of his/her neurological deficit.

- (b) Were there multiple neurological deficits occurring over a continuous period of at least 6 months? YES / NO*
If "YES", please give details (including dates of each episode):

- (c) Is there a well-documented history of exacerbations and remissions of said symptoms or neurological deficits? YES / NO*

- (d) Please provide details of all investigations performed. Please comment on whether the diagnosis was supported by MRI/CT scan.

- (e) Please give details of current treatment.

4. Has the Life Assured previously suffered from the condition specified above or any possible related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints? YES/NO*

If "YES", please give dates of diagnosis, their resulting diagnosis, the name and address of the doctor who made these diagnosis and source of information.

5. (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*

Date

Signature of Doctor

6. (a) 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

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

7. Please state and attach copies of all hospital, MRI/CT scan, laboratory and test results.

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

Date

Signature & Official Stamp of Doctor