

(d) Diagnosis: _____

(e) Date of FIRST diagnosis:

Day	Month	Year

(f) Diagnosis was first made by (Name of Doctor): _____

(g) Date diagnosis was made known to the Life Assured:

Day	Month	Year

(h) What was the exact information conveyed to the Life Assured?

3 DIAGNOSIS OF CANCER

(a) What was the site or organ involved and the precise histology of the tumour?

(b) What stage did the disease reach? Please describe this using whatever staging classification (e.g. TMN classification, etc) that is appropriate.

- (i) Was the disease completely localised? YES / NO*
- (ii) Was there invasion of adjacent tissues? YES / NO*
- (iii) Were regional lymph nodes involved? YES / NO*
- (iv) Were there distant metastases? YES / NO*

(c) If the diagnosis is leukaemia, please provide details of the actual type.

(d) If the diagnosis is malignant melanoma, please provide details of size, thickness (Breslow classification) and depth of invasion.

(e) In your opinion, please state if the advent of death is highly likely within 12 months (for Hospice Care benefit).

Date

Signature of Doctor

(f) Is the Life assured employed in the following industries?

YES / NO*

- Industries in contact with radioactive materials, asbestos, abrasive products
- Industries in contact with long term exposure to organic solvents such as painter, chemical engineers
- Industries in contact with long term exposure to pesticides
- Dry cleaning, laundry and ironing workers
- Manufacturing of tobacco products

If you have ticked any of the above boxes, please give full details.

(g) Type of treatment/ medication given and the response.

(h) Please tick if the following were done/ will be done.

- Radiotherapy
- Immunotherapy
- Stereotactic Radiotherapy
- Chemotherapy
- Hormone Therapy

(i) Is the current treatment related to the following conditions?

YES / NO*

If "YES", please tick the boxes.

- Pregnancy, childbirth, miscarriage or their sequelae, abortion, birth control, sterilisation, infertility or impotence tests or treatment.
- Alcoholism.
- Drug Addiction.
- Psychiatric treatment or treatment of mental or function disorder.
- Sexually-transmitted disease, AIDS or any illness caused by or related to the Human Immunodeficiency Virus.
- Self-inflicted injuries or attempted suicide, whether sane or insane.
- Resulting from nuclear weapon materials, ionizing radiation or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel.

If you have ticked any of the above boxes, please give full details.

Date

Signature of Doctor

(j) Is the Life Assured still on follow-up treatment? YES / NO*

If "YES", please specify the type of treatment/ medication.

(k) How frequently does the Life Assured seek treatment since discharge from hospital?

(l) What is the expected length of follow-up?

(m) Is there any purchase or rental of durable medical equipment? YES / NO*

If "YES", please state the durable medical equipment purchased or rented.

4 HOSPITALISATION

Please state the periods of hospitalisations.

Name of Hospital	Period(s) of Hospitalisation		Period(s) of Intensive Care	
	From	To	From	To

5 SURGERY (if applicable)

(a) Was surgery performed for this condition? YES / NO*

(i) If "YES", please specify.

Nature of Surgical Operation(s)	Date(s) Performed (DD/MM/YY)	Surgical Table No.

Date

Signature of Doctor

(ii) Was any surgical prosthesis used? YES / NO*

If "YES", please state the surgical prosthesis used.

(b) Is further surgery likely to be required? YES / NO*

If "YES",

(i) please specify the tentative date of surgery:

Day		Month		Year	

(ii) please specify the type of surgery to be performed:

(c) Is the surgery performed an elective cosmetic or plastic surgery? YES / NO*

If "YES", please provide details.

6 MEDICAL HISTORY

(a) Has the Life Assured previously suffered from the same illness in respect of which he is claiming now? YES / NO*

If "YES", please state:

(i) Date when illness was first diagnosed:

Day		Month		Year	

(ii) Name and address of the doctor who first treated him/ her.

(iii) Has the Life Assured fully recovered from the previous illness before the current episode? YES / NO*

(b) Has the Life Assured been admitted to any hospital before, either for the same or different cause? YES / NO*

If "YES", please state:

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) of Attending Doctor(s)

Date

Signature of Doctor

(c) Is the Life Assured suffering or has suffered from any other significant illnesses?

YES / NO*

If "YES", please state:

Brief Description of Illness(es)	Date(s) of First Diagnosis (DD/MM/YY)	Name & Address of Attending Doctor

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

Date

Signature & Official Stamp of Doctor