



3. (a) Has the Life Assured previously suffered from Bacterial Meningitis or any possible related illness? YES / NO\*

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

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(b) Please state if there is inflammation of the membranes of the brain or spinal cord. YES / NO\*

(c) Please provide details, including dates, of the extent of the neurological deficit.

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(d) Was there any neurological deficit 6 weeks after the date of diagnosis of Life Assured's meningitis? YES / NO\*

If "YES", please describe the neurological deficit.

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(e) Is this neurological deficit likely to be permanent? YES / NO\*

If "NO", please provide details.

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(f) Please provide details of investigations performed on the cerebrospinal fluid and blood culture, stating the types of organism found in each.

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(g) Please give details of current treatment.

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(h) Is the Life Assured HIV positive? YES/ NO\*

If "YES", please give full details.

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

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

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

5. (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.

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

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6. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

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

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Date

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Signature & Official Stamp of Doctor