



3. (a) Has the Life Assured's lung disease reach end-stage? YES / NO\*

If "YES", please provide the date when End Stage Lung Disease was FIRST diagnosed:

Day	Month	Year

(b) Please provide details of all investigations carried out, particularly pulmonary function tests including dates and results. (Please include current FEV 1 and vital capacity readings.)

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(c) Does the Life Assured require extensive and permanent oxygen therapy for hypoxemia? YES / NO\*

If "YES", please provide the start date:

Day	Month	Year

(d) Is there dyspnea at rest? YES / NO\*

(e) Is Life Assured's PaO2 < 55 mmHG? YES / NO\*

If "YES", please provide full details of all arterial blood gas analysis results.

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**This section is applicable to severe asthma condition only.**

4. (a) Is there evidence of acute attack of severe asthma with persistent status asthmaticus? YES / NO\*

If "YES", please provide details.

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(b) Was the Life Assured hospitalised and required assisted ventilation with a mechanical ventilator for a continuous period of at least 4 hours? YES / NO\*

If "YES", please explain.

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Date

Signature of Doctor

**This section is applicable to pulmonary emboli condition only.**

5. (a) Date when Life Assured first consulted you for pulmonary emboli:

Day		Month		Year	

(b) Date of any subsequent pulmonary embolism. Please provide dates of every recurrence.

Date	Medical Condition	Treatment Provided	Patient's Response	Name and Address of the doctor

(c) Is there surgical insertion of vena-cava filter? YES / NO\*

If "YES", please state the following:

(i) Date of surgery:

Day		Month		Year	

(ii) Was the surgery absolutely necessary? YES / NO\*

(iii) Is there other alternate treatment which could also treat the Life Assured's condition? YES / NO\*

If "YES", please state the type of treatment.

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**This section is applicable to pneumonectomy or complete surgical removal of a lung condition only.**

6. (a) Date of surgery:

Day		Month		Year	

(b) Reason(s) for requiring this surgery.

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(c) Was the surgery absolutely necessary? Please attach a copy of surgery and histology report. YES / NO\*

\_\_\_\_\_  
Date

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

7. (a) Has the Life Assured previously suffered from any illness related to the lung disease? YES / NO\*  
If "YES", please give dates of consultations, the diagnosis, the name and address of the doctor who made the diagnosis and source of information.

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- (b) Is there anything in the Life Assured's family history which would have increased the risk of lung disease? YES / NO\*  
If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

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- (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.

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

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8. (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\*

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Date

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Signature of Doctor

9. (a) Did the Life Assured consult any other doctor for 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, together with the names of the consultants attended.

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10. Please state and attach copies of all relevant hospital reports, laboratory and test results.

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11. 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