(b) Did coma resulting directly from alcohol, drug abuse or mentally induced coma? YES / NO*

If "YES", please give full details.

(c) How many hours was the Life Assured in a state of coma, with no response to external stimuli?

(d) Was the Life Assured put on life support measures? YES / NO*

If "YES", please give details of the life support measures.

(e) Please provide the date and time when the Life Assured emerged from the state of coma, with no response to external stimuli.

(f) Was there any form of permanent neurological deficit 30 days after the onset of the coma? YES / NO*

If "YES", please furnish details.

This section is applicable to severe epilepsy condition only.

4. (a) If you are not the Life Assured's usual medical doctor, please provide the name, address and qualification of the Life Assured's usual medical doctor.

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

Date

Signature of Doctor

Claims Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

(c) How was this diagnosis established? Please include a copy of diagnostic investigation reports (e.g electroencephalography (EEG), Managetic Resonance Imaging (MRI), Position Emission Tomography (PET), etc).

_____

_____

(d) Date when epilepsy was first diagnosed: Day | Month | Year

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

(f) Date when the Life Assured first became aware of this condition: Day | Month | Year

(g) Has the Life Assured experienced recurrent unprovoked tonic-clonic or grand mal seizures, and be known to be resistant to optimal therapy as confirmed by drug-serum level testing? YES / NO*

If "YES", please provide the following:-

(i) Dates of attacks: _____

(ii) Frequency of such attacks per week: _____

(h) Has the Life Assured undergone any form of neuro surgery for the treatment of epileptic seizures? YES / NO*

If "YES", please provide the date. Day | Month | Year

(i) Is the epilepsy due to febrile seizures alone? YES / NO*

(j) Is the epilepsy due to absence (petit mal) seizures alone? YES / NO*

(k) Is the Life Assured taking prescribed anti-epileptic (anti-convulsant) medication? YES / NO*

If "YES", please state the type(s) of each medication prescribed and duration of he medications.

_____

(l) Would you consider the Life Assured to be on optimal drug therapy? YES / NO*

If "YES", please state the period the Life Assured has been taking prescribed anti-epileptic (anti-convulsant) medication.

From Day | Month | Year to Day | Month | Year

_____ _____

Date Signature of Doctor

Claims Department
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5. (a) Is there anything in the Life Assured's personal medical history which would have increased the risk of coma or epilepsy? YES / NO*

If "YES", please give full details including the date of diagnosis, name and address of attending doctor and soure of information.

(b) Is there anything in the Life Assured's family history which would have increased the risk of coma or epilepsy? YES / NO*

If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

(c) Does the Life Assured have any personal history of epilepsy, 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.

(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.

6. (a) Please describe the Life Assured's mental and cognitive abiliites.

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

7. (a) Did the Life Assured consult other doctors for any illness or condition leading to coma 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

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

8. Please state and attach copies of radiological, CT scanning reports, electroencephalography (ECG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET), HIV and antibody tests and supply details of laboratory of any other tests done (whichever is applicable).

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

Date

Signature & Official Stamp of Doctor

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Jun 2017