3. (a) Has the Life Assured previously suffered from any ear disease or any related illness ? YES / NO*
If "YES", please give dates of consultations, the resulting diagnosis and the name and address of the attending doctor.

______________________________________________

______________________________________________

(b) Is there total loss of hearing of at least 80 decibels in all frequencies of hearing in both ears? YES / NO*
If “YES”, please provide supporting evidence (e.g audiogram, etc).

______________________________________________

______________________________________________

(c) Is the hearing loss irreversible? YES / NO*

(d) Is there surgery available that could reinstate hearing in either or both ears? YES / NO*
If “YES”, please state nature of surgery and tentative date of surgery.

(e) Please state the best corrected hearing frequency for both ears.

Left ______________________ Right ______________________

Please provide supporting evidence (e.g audiogram, etc).

**This section is applicable to Cavernous Sinus Thrombosis condition only.**

4. (a) Date of first diagnosis of Cavernous Sinus Thrombosis:

| Day | | Month | | Year | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

(b) How was this diagnosis established? (Please include a copy of diagnostic investigation report).

______________________________________________

______________________________________________

(c) Was surgery carried out to treat Cavernous Sinus Thrombosis? YES / NO*
If “YES”, please specify:-

(i) Type of surgery:______________________________________________

(ii) Date of surgery:

| Day | | Month | | Year | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

______________________ ______________________
Date Signature of Doctor

(d) Is there other mode of treatment other than the above surgery which could have been used to treat the Life Assured's Cavernous Sinus Thrombosis? YES / NO*

If "YES", please state the following:-

(i) Date of treatment:

| Day | | Month | | Year | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

(ii) Mode of treatment:______________________________

**This section is applicable to cochlea or auditory nerve conditions only.**

5. (a) Date of first consultation of cochlea or auditory nerve condition:

| Day | | Month | | Year | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

(b) Was there total and permanent loss of hearing as a result of cochlea or auditory nerve condition? YES / NO*

(c) Was surgical cochlea implant performed for the cochlea or auditory nerve condition? YES / NO*

If "YES", please state the date of surgery:

| Day | | Month | | Year | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

(d) Was other surgery carried out to treat the cochlea or auditory nerve condition? YES / NO*

If "YES", please specify:

(i) Date of surgery:

| Day | | Month | | Year | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

(ii) Type of surgery done:

(e) Is there other mode of treatment which could have been used to treat the Life Assured's cochlea/auditory nerve condition? YES / NO*

6. (a) Is there anything in the Life Assured's lifestyle or personal medical history which would have increased the risk of deafness? YES / NO*

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

______________________________

______________________________

(b) 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.

______________________________

______________________________

______________________ ______________________

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

7. (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*

8. (a) Did the Life Assured consult any other doctor for this illness of 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 name(s) and address(es) of any hospital or clinic to which the Life Assured was referred, together with the names of the consultants attended.

______________________________________________________________________

______________________________________________________________________

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

______________________________________________________________________

______________________________________________________________________

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

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______________________________________________________________________

_____________________ _____________________
Date Signature & Official Stamp of Doctor

Claims Department
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