

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

If "YES", please give full details.

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

(d) Is the disease caused by HIV infection? YES / NO*

If "YES", please provide details.

(e) What is the prognosis?

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

(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.

Date

Signature of Doctor

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

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

Date

Signature & Official Stamp of Doctor