

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

(f) Date when Life Assured first became aware of the condition:

Day	Month	Year

3. (a) Please provide full and exact details of the diagnosis including the type(s) of virus involved.

(b) Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? YES / NO*
If "YES", please give details.

4. Please confirm on the following:-

(a) Was a liver biopsy performed? YES / NO*

If "YES", please state date of biopsy:

Day	Month	Year

(b) Is there a submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure? YES / NO*

If "YES", please assist to confirm if there is any of the following:-

(i) Rapid decreasing of liver size? YES / NO*

If "YES", please advise the state of the liver and its lobular architecture.

(ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework? YES / NO*

If "YES", please advise the extent of the liver necrosis and its lobular architecture.

Date

Signature of Doctor

(iii) Rapid deterioration of liver function test? YES / NO*

If "YES", please provide the results.

(iv) Deepening jaundice YES / NO*

If "YES", please give full details.

(v) Signs of hepatic encephalopathy? YES / NO*

If "YES", please give full details.

5. (a) Was there radiological evidence of oesophageal varices? YES / NO*

(b) Was there evidence of bleeding from the oesophageal varices? YES / NO*

If "YES", please state episode(s) of bleeding.

6. (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*

Date

Signature of Doctor

7. Does the Life Assured have any other medical conditions?

YES / NO*

If "YES", please state medical condition, date of diagnosis and name & address of treating doctor.

Medical Conditions	Diagnosis Date (DD/MM/YYYY)	Name and Address of Doctor who treated Life Assured

8. Does the Life Assured have any family history?

YES / NO*

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

Relationship to the Life Assured	Nature of Condition	Age of Onset

9. Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

10. Please give details of the Life Assured's habit in relation to alcohol consumption including the amount of alcohol consumption per day and source of information.

11. Please provide any other information which may be of assistance to us in assessing this claim.

Date

Signature & Official Stamp of Doctor