

3. (a) What type of surgery was performed?

(b) Date of Surgery:

Day	Month	Year

(c) Was it an open-heart surgery? YES / NO*

If "NO", please state exact form of intervention.

(d) Name and address of Hospital.

(e) Name and address of Doctor who performed the surgery.

4. (a) Has the Life Assured previously suffered from any related illness, e.g Hypertension, Angina, other Vascular Disease, Rheumatic Fever, etc? YES / NO*

If "YES", please give dates of diagnosis, the resulting diagnosis, name and address of doctor and source of information.

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

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

(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.

Date

Signature of Doctor

(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, name and address of attending doctor.

5. (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*

6. (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 referred.

7. Please state and attach copies of results of cardiac catheterisation/echocardiogram report and other hospital, laboratory and test results.

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

Date

Signature & Official Stamp of Doctor