

(b) What is the current condition of the Life Assured and what is the prognosis?

(c) Was there impaired motor function or respiratory weakness?

YES/NO*

If "YES", please provide details.

(d) What is the nature of treatment?

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 address of any hospital or clinic to which the Life Assured was referred to and the name of the consultants attended.

Date

Signature of Doctor

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