3. (a) Details of current symptoms and treatment.

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(b) Has active therapy now been rejected in favour of relief of symptoms?

____

____

(c) Can you confirm that the advent of death is highly probable within 12 months?

____

____

4. (a) Has the Life Assured previously suffered from the condition specified above or any possible related illnesses? YES / NO*
If "YES", please give dates of consultations and the resulting diagnosis.

____

____

(b) Is there anything in the Life Assured's personal medical history which would have increased the risk of the condition resulting in terminal illness? YES / NO*
If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

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____

(c) Is there anything in the Life Assured's family history which would have increased the risk of the terminal condition? YES / NO*
If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

____

____

(d) 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.

____

____

(e) 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

5. (a) Please describe the Life Assured's mental and cognitive abiliites.

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____

(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 attended.

7. Please state and attach copies of all hospital reports, 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

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