3. (a) Please provide the full and exact details of the diagnosis.

_____

_____

(b) Date when illness was FIRST diagnosed: Day | Month | Year

(c) Diagnosis was first made by (name of doctor): _____

(d) Date when the Life Assured first became aware of the condition: Day | Month | Year

(e) Date when the Life Assured's PARENT first became aware of the condition: Day | Month | Year

4. (a) Is the condition acute or chronic?

_____

_____

(b) In clinical terms, is the condition mild, moderate or severe? Please provide details regarding the severity of the condition.

_____

_____

(c) Has the Life Assured missed anytime off work or school due to this condition and for which medical certificates were provided?

_____

_____

5. Please provide details of hospitalisation below.

Name & Address of Hospital	Date of Admission	Date of Discharge

6. Please provide details with dates whether the Life Assured was placed on assisted ventilation with a mechanical Ventilator machine (including number of hours on the machine).

_____

_____

_____ _____

Date Signature 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

7. (a) Please provide details of all treatment prescribed.

_____

_____

(b) Is the Life Assured on continuous daily use of oral corticosterioids? YES / NO*
If "YES", please state duration of use.

_____

_____

8. Please provide details of all investigations performed and attach a copy of the laboratory / investigation results.

_____

_____

9. Does the Life Assured have significant growth impairment:

(a) Due to asthma? YES / NO*

(b) Evidenced by the Life Assured's height below the third percentile for his / her age and sex? YES / NO*

(c) Where the Life Assured's height has previously been recorded at or above the fifth percentile at a routine development examination.State Life Assured's age at this examination. Age _____ YES / NO*

10. (a) Please provide details of all recording of the Life Assured's peak expiratory rate below.

Date of Recording	Maximum peak expiratory flow rate	Is rate less than 80% that predicated for a child of same age, sex and build?

(b) Was the Life Assured complying with optimal medication throughout the period of these recordings? YES / NO*
Please state medication used.

_____

_____ _____

Date Signature of Doctor

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11. Has the Life Assured previously suffered from the condition specified above or any related illness? YES / NO*
If "YES", please give details including dates of consultations and the resulting diagnosis.

12. 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

13. Please provide dates and results of all HIV and antibody tests done. Please also attach copies of all relevant laboratory reports.

14. Does the Life Assured have any personal history of any other major medical or psychiatric condition? YES / NO*
If "YES", please give details including nature of condition, date of onset, treatment received and current status of the condition.

15. Does the Life Assured have any family history of any major medical condition? YES / NO*
If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

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

Date

Signature & Official Stamp of Doctor

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Jun 2017