



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

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(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 there widespread joint destruction?

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(b) Where and how did the accident or injury occur?

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(c) Were there any reasons to indicate that there were contributory factors leading to the accident or injury (eg. Under the influence of drugs, self-inflicted injury etc.)?

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

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6. (a) Please give details of any resulting neurological impairments.

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

(b) What is the extent of the Life Assured's expected recovery from these impairments?

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

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7. (a) Please give details of any loss of intellectual capacity.

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(b) What is the extent of the Life Assured expected recovery from this intellectual loss?

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(c) Is the intellectual loss permanent? Please elaborate.

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(d) Please provide details of any tests done to assess intellectual capacity eg. IQ or Denver Development Screening Tests.

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

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9. 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.

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

10. 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

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

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12. 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.

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13. 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.

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

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Date

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Signature & Official Stamp of Doctor