



## B. DETAILS OF MAJOR DISEASE / CRITICAL ILLNESS

6. (a) What is the diagnosis? Please provide full details of the diagnosis. \_\_\_\_\_

(b) Date of onset

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yyyy

[illegible]

(d) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

Name of Doctor	Name of Clinic/ Hospital and Address

[illegible]

(e) Was the patient admitted in the hospital? ☐ Yes ☐ No

If yes, please provide the following details.

Name / Address of Hospital \_\_\_\_\_

Date of Admission \_\_\_\_\_ Date Discharged \_\_\_\_\_ No. of Days \_\_\_\_\_

7. (a) Please describe the extent of Blindness.

(b) Do you consider the Blindness as total and irreversible loss of all sight of both eyes? ☐ Yes ☐ No

If yes, please provide basis for details.

8. Please provide details of current treatment provided.

9. What is the prognosis?

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10. Please provide full details of tests and results which have been performed to establish the diagnosis of Blindness, and attach copies of all relevant hospital reports, laboratory and test results, including neurological reports, CT scans, MRI and other imaging studies and surgical reports.

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11. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

### C. MEDICAL HISTORY

12. Has the patient previously suffered from the condition specified above or any related illnesses? ☐ Yes ☐ No

If yes, please provide details including date of consultations, their resulting diagnosis, the name and address of attending. Please state source of information. \_\_\_\_\_

Date of Consultation	Name of Doctor / Address	Diagnosis

13. Is there anything in the patient's medical history which would have increased the risk of Blindness?

☐ Yes ☐ No

If yes, please provide details including the date of consultations, their resulting diagnosis, name and address of attending doctor. Please state source of information. \_\_\_\_\_

Date of Consultation	Name of Doctor / Address	Diagnosis

14. Please give details of the patient's family history which would have increased the risk of Blindness (including the relationship, nature of illness, date of diagnosis) Please state source of information. \_\_\_\_\_

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15. Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day. Please state source of information.

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16. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day. Please state source of information. \_\_\_\_\_

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17. Does the patient have or ever had any other significant health condition(s)? ☐ Yes ☐ No

If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

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**D. ADDITIONAL INFORMATION**

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

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**I hereby certify that the above statements are true and complete to the best of my knowledge and belief.**

\_\_\_\_\_  
**Name of Attending Physician (Please print)**

\_\_\_\_\_  
**Degree/Specialty**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**PRC Number / PTR Number**

\_\_\_\_\_  
**Telephone Number (s)**

**To the Attending Physician :** You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.