

C. MEDICAL HISTORY

12. Has the patient previously suffered from Coronary Artery Disease or any related illnesses?

Yes

No

If "YES", please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor and source of information.

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

Yes

No

If "YES", please provide details including the date of diagnosis, name and address of attending doctor and source of information.

14. Please give details of the patient's family history, which would have increased the risk of Coronary Artery Disease (including the relationship, nature of illness, date of diagnosis and source of information).

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 and source of this information.

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

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

If "YES", please provide details including dates of consultations, their resulting diagnosis, the name and address of attending doctor and source of information.

D. ADDITIONAL INFORMATION

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

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp