

(d) Has the tumour caused permanent neurological deficits? Yes No

If "YES", please provide full details.

8. (a) Is the tumour a cyst? Yes No

(b) Is the tumour a granuloma? Yes No

(c) Is the tumour a vascular malformation? Yes No

(d) Is the tumour a haematoma? Yes No

(e) Is the tumour in the pituitary gland or spinal cord? Yes No

9. Please provide full details of current treatment provided.

10. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g., CT scans, MRI report, surgical reports, histopathology reports neurological reports and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

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 the doctors consulted.

C. MEDICAL HISTORY

12. Has the patient previously suffered from Benign Brain Tumour 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 Benign Brain Tumour?

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 Benign Brain Tumour (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