

10. Is there any surgery available that could reinstate vision in either or both eyes? Yes No
If yes, please state type of surgery, whether such surgery is recommended for the patient, and tentative date of surgery.

11. What is the prognosis?

12. Please confirm whether blindness in both eyes is total and irreversible. Yes No

13. *Is the blindness permanent?* Yes No

14. 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

15. Has the patient previously suffered from any eye disease or any related illness? Yes No
If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor and source of information.

16. Is there anything in the patient's medical history which would have increased the risk of Blindness? If yes, please provide full details including the date of diagnosis, name and address of attending doctor and source of information. Yes No

17. Has any of the patient's family (whether living or deceased) suffered from any eye disease including blindness, cataract, glaucoma or retinitis pigmentosa? If yes, please give full details including the relationship, nature of illness, date of diagnosis and source of information. Yes No

18. 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.

19. 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.

20. Does the patient have or ever had any other significant health condition(s)? If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received. Yes No

D. ADDITIONAL INFORMATION

21. 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**