

(e) Was there any permanent neurological deficit 30 days after the onset of the Coma? Yes No
If yes, please furnish details.

8. Please provide full details of tests and results which have been performed to establish the diagnosis of Coma, 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.

9. Please provide details of treatment administered.

10. Please provide the date and time of emergence from the state of no response to external stimuli.

Date Time

11. What is the current condition of the patient?

12. What is the prognosis?

13. Was the Coma resulting directly from alcohol or drug abuse? Yes No
If yes, please provide full details.

14. Is the Coma as a result of a self-inflicted act? Yes No
If yes, please provide full details.

15. 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

16. Has the patient previously suffered from any related illness that caused the Coma? Yes No
If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor and source of information.

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

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

19. 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.

20. 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.

21. 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.

D. ADDITIONAL INFORMATION

22. 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