

8. Please confirm whether deafness in both ears is total and irreversible. Yes No

9. Please provide full details of tests and results which have been performed to establish the diagnosis of Deafness, and attach copies of all relevant hospital reports, laboratory and test results, including audiogram reports etc.

10. Please provide details of treatment administered.

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

12. What is the current condition of the patient?

13. What is the prognosis?

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 ear 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 lifestyle or medical history which would have increased the risk of Deafness? 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 Deafness (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**