





9. Is there reason to suspect that there were contributory circumstances which led to the injury, e.g. under the influence of alcohol, fits, etc.?

Yes  No

If "YES", please give details.

10. Was the accident reported to the police?  Yes  No

If "Yes", please provide us with the name of the police station at which the accident was reported and the police report. If "No", please provide reason why not.

11. Is the major head trauma due to spinal cord injury?  Yes  No

If "YES", please give details.

12. Did the injury result from a self-inflicted act?  Yes  No

If "YES", please give details.

13. Were there any neurological deficit(s) present 6 weeks after the date of accident?  Yes  No

If "YES", please give details.

14. Is this neurological deficit likely to be permanent?

Yes

No

If "YES", please give details. If "NO", please state the date which the patient is expected to recover from these neurological deficits.

15. Is there a possibility that the impairment could regress in the future?

Yes

No

If "YES", please give details.

16. What is the prognosis?

17. Please provide full details of treatment administered.

18. Has the patient refused any form of medical treatment, e.g. surgery, which may have prevented or reduced the severity of the impairment?

Yes

No

If "YES", please give details.

19. Please provide full details of tests and results which have been performed to establish the diagnosis of Major Head Trauma, and attach copies of all relevant hospital and surgical reports, laboratory and test results, including Magnetic Resonance Imaging, CT Scan and Computerised Tomography.

20. 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

22. Has the patient previously suffered from any illness related to the present condition?  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.

23. Is there anything in the patient's habits or personal history which would have increased the risk of accident or injuries?

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.

24. 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.

24. 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.

25. 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**

26. 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**