





10. Please comment on whether the diagnosis was supported by MRI / CT scanning.

11. Please describe the extent of the Multiple Sclerosis.

(a) Is there a history of repeated relapse and remission or a steady progressive disability?  Yes  No

(b) *Are there lesions producing well defined neurological deficits involving the optic nerves, brain stem and spinal cord?*  Yes  No

(c) Are there signs and symptoms of multiple episodes?  Yes  No

12. Was the neurological damage caused by Systemic Lupus Erythematosus (SLE) or Human Immunodeficiency Virus?  Yes  No  
If yes, please give details.

13. Please provide full details of current treatment provided.

14. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g., resting ECGs, ultrasound, surgical reports, X-rays, MRI/CT scans, neurological reports and any other imaging studies, laboratory evidence etc., and other relevant hospital reports.

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 the condition specified above or any related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints?  Yes  No  
If yes, please give date of diagnosis, their 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 multiple sclerosis? If yes, please provide full details including the date of diagnosis, name and address of attending doctor and source of information.  Yes  No

18. Please give details of the patient's family history which would have increased the risk of multiple sclerosis (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**