

10. Has active treatment and therapy now been rejected in favour of relief of symptoms? Yes No

If "YES", please give details why this opinion or course of action is taken?

11. In your opinion,

(a) How long is the life expectancy of the patient? _____ Months

Please explain and give supporting medical evidence to substantiate your opinion?

(b) Is the patient's condition incurable and beyond any hope of recovery? Yes No

(c) Is the advent of death highly probable within 6 months from date of diagnosis? Yes No

(d) Is the advent of death highly probable within 12 months from date of diagnosis? Yes No

(e) Is the patient currently an in-patient in a hospital, nursing home or hospice? Yes No

14. Please provide details of all investigations/test performed and attach copies of results of any investigations performed, e.g., resting ECGs, exercise stress tests, surgical reports, X-rays, CT scans, 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

17. Has the patient previously suffered from the condition specified above or any related illnesses?

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.

18. Is there anything in the patient's medical history which would have increased the risk of the condition resulting in Terminal Illness?

Yes No

If "YES", please provide details including the date of diagnosis, name and address of attending doctor and source of information.

19. Please give details of the patient's family history, which would have increased the risk of the condition resulting in Terminal Illness (including the relationship, nature of illness, date of diagnosis and source of information).

20. 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.

21. 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.

22. 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

23. 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