







(j) Is there a history of this condition or any condition likely to have contributed to or be connected with the patient's present condition?  Yes  No

If yes, please provide details.

---

---

---

(k) Please provide a full history of all consultations and treatments for the patient.

Date	Reasons for consultations including nature of symptoms and diagnosis and results of tests performed	Treatment Prescribed	Results

(l) Is there a family history of this condition?  Yes  No

If yes, please provide information such as relationship to insured, age first diagnosed, nature of condition and age at onset etc.

---

---

---

---

---

---

(m) Are you completing claim forms on behalf of the patient for any other insurance companies in relation to this condition?  Yes  No

If yes, please provide the name of the company (ies).

---

---

**For Questions (n) to (r), please refer to the attached claim form for details of the patient's occupation.**

(n) Is the patient able to perform all the normal duties of his/ her usual occupation?  Yes  No

If yes, when is he/ she expected to return to his/ her usual occupation? \_\_\_\_\_ / \_\_\_\_\_  
mm yy

(o) If he/she is unable to return to his/ her usual occupation, is he/she able to engage in any other occupation?  
 Yes  No

If YES, please provide us the following details.

(i) What types of occupation can he/ she engage in?

\_\_\_\_\_  
\_\_\_\_\_

(ii) When is he/ she expected to engage in these occupations? \_\_\_\_\_ / \_\_\_\_\_  
mm yy

If NO, to what extent does the disability prevent the patient from performing all the normal duties of his /her occupation, i.e. \_\_\_\_\_?

(p) Date the patient was obliged to cease work? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yy

(q) In your opinion, is the disability " total and permanent and such that there is neither then nor at any time thereafter any work, occupation or profession that the person concerned can ever sufficiently do or follow to earn to obtain any wages, compensation or profit"?  Yes  No

If yes, when did such commence? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd mm yy

(r) Please provide full details of the patient's capabilities and limitations in relation to his/ her occupation.

(i) Capabilities (what the patient can do)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ii) Limitations (what the patient cannot do)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



(d) Is the patient suffering or has suffered from any other significant illnesses?  Yes  No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

(e) Are you the patient's regular doctor?  Yes  No

If yes, since when? \_\_\_\_/\_\_\_\_/\_\_\_\_  
                                  dd          mm          yyyy

If no, please provide the name and address of the patient's regular doctor.

---

---

---

(f) Please give any other information which you feel would be helpful in assessment of the patient's claim.

---

---

---

---

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp