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| Policy No. |
| Claim No. <small>(For internal use)</small> |

To be completed by the Attending Physician at Insured's expense.

1. PATIENT'S PARTICULARS

Name of the patient: _____ NRIC/Passport No: _____

Date of Birth: _____ Sex: _____ Admission No: _____ Ward No: _____

Date of Admission: _____ Date of Discharge: _____

2. DETAILS OF PATIENT'S CONDITION

In order for a claim under this policy to be paid, the following definition must be satisfied:

The actual undergoing as a recipient of a transplant of bone marrow.

(a) Please describe the exact details of the patient's condition.

(b) Date you were first consulted for the condition: _____ / _____ / _____
dd mm yyyy

(c) What are the signs or symptoms presented at that time?

| Signs or Symptoms presented | Date first appeared |
|-----------------------------|---------------------|
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(c) 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 |
|---------|-------------------------|--------------------------------------|
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(d) Did you refer the patient to any other doctor(s)? Yes No

If yes, please provide the name and address of the doctor(s).

(e) 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