Dear claimant,

We are sorry to learn about your illness.

In order for us to process your claim, we require the following:

1. Claimant’s Statement
2. Doctor’s Statement (medical fee to be borne by policyholder)
3. Declaration of Beneficial Ownership (for Trust / Keyman Policy)
4. Authorisation Form For Medical Report
5. Histopathological / biopsy reports (for cancer)
6. ECG reading, cardiac enzymes assays & troponin reports (for heart attack)
7. CT scan / MRI scan results (for stroke)
8. Available laboratory and test results
9. Copy of NRIC of claimant

Once we have received all the above required documents, we will process your claim and inform you of the outcome as soon as possible.

Submission of Claim Documents

Please submit all claim documents:

(I) Through your servicing adviser; OR
(II) Personally or by post to the below address:

Customer Service Section
20 McCallum Street
#07-01 Tokio Marine Centre
Singapore 069046

Note:

(a) This form is to be completed for making a claim of benefits under Dread Disease / Critical Illness, EarlyCare, CancerCare and Terminal Illness.

(b) Critical Illness was formerly known as Dread Disease in our policy contracts
INDIVIDUAL DREAD DISEASE / CRITICAL ILLNESS / TERMINAL ILLNESS CLAIMANT’S STATEMENT

IMPORTANT NOTES:
(1) The issue of this claim form is not an admission of liability.
(2) This claim form is to be completed by the Assured.
(3) Tokio Marine Life Insurance Singapore Ltd. reserves the right to request for additional medical reports when it deems necessary.

CLAIMANT’S STATEMENT: TO BE COMPLETED BY ASSURED

PART 1: DETAILS OF POLICY(IES)
1.1 Policy No.:
   (a) ____________________ (b) ____________________
   (c) ____________________ (d) ____________________

PART 2: DETAILS OF ASSURED
2.1 Name:
   ____________________ (as stated in NRIC / Passport)

2.2 NRIC / Passport No.:

2.3 Residence address:

2.4 Occupation:

PART 3: DETAILS LIFE ASSURED [if different from Part (2)]
3.1 Name:
   ____________________ (as stated in NRIC / Passport)

3.2 NRIC / Passport No.:

3.3 Residence address:

3.4 Occupation:

3.5 Contact no.:
   ___________ (H) ___________ (O) ___________ (HP)

PART 4: DETAILS OF ILLNESS(ES) / MEDICAL CONDITION(S) OF LIFE ASSURED

4.1 Describe fully the symptoms experienced for which the Life Assured consulted a doctor:

4.2 When did the symptoms first appear before the Life Assured consulted a doctor?

   ____________________ (dd/mm/yyyy)

4.3 Date when the Life Assured first consulted a doctor for the above symptoms:

   ____________________ (dd/mm/yyyy)

Signature of Assured: ____________________
Date (dd/mm/yyyy): ____________________
4.4 If consultation was for illness, describe fully the nature and extent of the Life Assured’s illness:

____________________________________________________________________________________

4.5 If consultation was due to an accident, describe fully the nature of the Life Assured’s injuries and how it happened:

____________________________________________________________________________________

4.6 Has the Life Assured previously suffered from or received treatment for a similar / related illness? □ Yes □ No
If yes, please provide details:

____________________________________________________________________________________

PART 5 : DETAILS OF MEDICAL CONSULTATIONS / HOSPITALISATION

5.1 Please provide details of doctor(s) whom the Life Assured has consulted in connection to his/her illness:

<table>
<thead>
<tr>
<th>Name of doctor / hospital</th>
<th>Address</th>
<th>Date of first consultation / hospitalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

5.2 Please provide details of the Life Assured’s regular doctor(s), date and reason(s) of consultation:

<table>
<thead>
<tr>
<th>Name of doctor</th>
<th>Address</th>
<th>Date of consultation</th>
<th>Reason(s) of consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

PART 6 : OTHERS

6.1 Has any of the Life Assured’s family members suffered from a similar / related illness? □ Yes □ No

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Nature of illness</th>
<th>Date of diagnosis (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Signature of Assured ___________________________ Date (dd/mm/yyyy) ___________________________
6.2 Does the Life Assured smoke cigarette? □ Yes □ No
If yes, what is the Life Assured’s daily consumption?
Sticks

How long has the Life Assured been smoking?
_____ years _____ months

PART 7: OTHER INSURANCES

7.1 Was the Life Assured insured with other insurance company(ies)? □ Yes □ No
If yes, please provide the following details:

<table>
<thead>
<tr>
<th>Name of insurance company</th>
<th>Date of issue</th>
<th>Sum assured</th>
<th>Type of plan</th>
<th>Claim amount</th>
<th>Claim notified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PART 8: PAYMENT TO SINGAPORE BANK ACCOUNT

8.1 Please attach a copy of your bank statement or passbook showing your name and bank account details.

<table>
<thead>
<tr>
<th>Bank Name</th>
<th>Account No</th>
<th>Account Holder Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PART 9: DECLARATION FOR COMMON REPORTING STANDARD (CRS)

9.1 Please provide information on your Tax Residency. (This will usually be where you are liable to pay income taxes.)

<table>
<thead>
<tr>
<th>Country of Tax Residence</th>
<th>Taxpayer Identification Number (TIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Singapore, TIN for Individuals would be your NRIC/FIN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country of Tax Residence</th>
<th>Taxpayer Identification Number (TIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Singapore, TIN for Individuals would be your NRIC/FIN</td>
</tr>
</tbody>
</table>

If no TIN available, enter Reason A, B or C:

Reason A The country where you are liable to pay tax does not issue TINs to its residents.
Reason B You are otherwise unable to obtain a TIN or equivalent number (Please explain why you are unable to obtain a TIN in the below table if you have selected this reason).
Reason C No TIN is required. (Note: Only select this reason if the authorities of the country of tax residence entered below do not require a TIN to be disclosed).

If you are a tax resident in more than two countries, please use a separate Individual Tax Residency Self-certification Form.

For more information on Common Reporting Standard, you can refer to our company website. (http://www.tokiomarine.com/sg/en/about-us/crs.html)

For Entity and/or Controlling Persons, please complete the Entity Tax Residency Self-Certification Form and/or Controlling Person Tax Residency Self-Certification Form (forms can be obtained from the same website). If you have any questions on how to define your tax residency status, please visit the IRAS website or speak to a professional tax adviser as we are not allowed to give tax advice.
Personal Data Notice

I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd. ("Tokio Marine Insurance Group") may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or the Tokio Marine Insurance Group’s Data Protection Policy available at www.tokiomarine.com which I / we have read, understood and agreed to the same.

Declaration

I / We agree that:
(i) all answers given by me / us in this form are, to the best of my / our knowledge and belief, true and complete;
(ii) Tokio Marine Life Insurance Singapore Ltd ("TMLS") shall not be deemed to provide cover and neither shall TMLS be liable to pay any claim, provide any benefit under the Policy/relevant Policy or be required to process any request made to the extent that the provision of such cover, payment of such claim, provision of such benefit or processing of such request would expose TMLS (or its parent company or holding company (in both instances, whether direct or indirect) or the subsidiaries of its parent or holding company) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the applicable jurisdiction, Singapore, the European Union, United Kingdom or United States of America;
(iii) where TMLS becomes aware that I/We, the Life Assured or any person or entity connected with the Policy/relevant Policy (see paragraph (iv) below) is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned in paragraph (ii), TMLS shall be entitled to block, suspend and/or terminate the Policy/relevant Policy at any time including but not limited to, not making or receiving any payments under the Policy/relevant Policy. The decision of TMLS on the aforementioned is final; and
(iv) a person or entity connected with the Policy/relevant Policy includes an assignee, a beneficiary, a trustee, an executor, an administrator, a director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, for my/our beneficial owners or beneficiaries’ beneficial owners. As an ongoing obligation, I/We will immediately inform TMLS if there are any changes to the identities, status/constitution/establishment, particulars and identification documents of these persons.

I / We hereby also authorize:
(a) any medical source, insurance office, or organization to release to or when requested to do so by TMLS, any relevant information concerning the below-named assured, and;
(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning the below-named assured, at any time.

A photocopy of this authorization shall have the same effect as the original.

______________________________
Signature of Assured

Date: ____________________________
(dd/mm/yyyy)

Name(s): ________________________

NRIC No(s): _______________________

Address(es): _______________________

Email Address: _____________________

Contact No(s): (HP) _______________

Relationship to Life Assured: _______________
INDIVIDUAL DREAD DISEASE / CRITICAL ILLNESS / TERMINAL ILLNESS CLAIM DOCTOR’S STATEMENT

Name of Patient: ___________________________ NRIC / Passport No: _______________________
(as stated in NRIC / Passport)

INSTRUCTIONS: Please tick [✓] in the appropriate box and complete the relevant sections in respect to the illness claimed. Please submit ONLY the relevant sections to us upon completion.

<table>
<thead>
<tr>
<th>Section to be completed</th>
<th>Sections to be completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s Disease / Severe Dementia</td>
<td>1 &amp; 11</td>
</tr>
<tr>
<td>Apallic Syndrome</td>
<td>1 &amp; 12</td>
</tr>
<tr>
<td>Aplastic Anaemia</td>
<td>1 &amp; 13</td>
</tr>
<tr>
<td>Bacterial Meningitis</td>
<td>1 &amp; 14</td>
</tr>
<tr>
<td>Benign Brain Tumour</td>
<td>1 &amp; 15</td>
</tr>
<tr>
<td>Blindness / Optic Nerve Atrophy</td>
<td>1 &amp; 16</td>
</tr>
<tr>
<td>Cardiac Pacemaker / Defibrillator Insertion</td>
<td>1 &amp; 17</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>1 &amp; 18</td>
</tr>
<tr>
<td>Coma / Severe Epilepsy</td>
<td>1 &amp; 19</td>
</tr>
<tr>
<td>Coronary Artery By-pass Surgery / Angioplasty &amp; Other Invasive treatment for Coronary Artery / Other Serious Coronary Artery Disease</td>
<td>1 &amp; 20</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td>1 &amp; 21</td>
</tr>
<tr>
<td>Deafness (Loss of Hearing)</td>
<td>1 &amp; 22</td>
</tr>
<tr>
<td>Dengue Haemorrhagic Fever</td>
<td>1 &amp; 23</td>
</tr>
<tr>
<td>Diabetic Complications</td>
<td>1 &amp; 24</td>
</tr>
<tr>
<td>Encephalitis</td>
<td>1 &amp; 25</td>
</tr>
<tr>
<td>End Stage Liver Failure / Liver Disease</td>
<td>1 &amp; 26</td>
</tr>
<tr>
<td>End Stage Lung Disease / Severe Asthma</td>
<td>1 &amp; 27</td>
</tr>
<tr>
<td>Fulminant Hepatitis / Biliary Tract Disease</td>
<td>1 &amp; 28</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>1 &amp; 29</td>
</tr>
<tr>
<td>Heart Valve Surgery</td>
<td>1 &amp; 30</td>
</tr>
<tr>
<td>HIV Due To Blood Transfusion and Occupational Acquired HIV</td>
<td>1 &amp; 31</td>
</tr>
<tr>
<td>Kidney Failure / Chronic Kidney Disease</td>
<td>1 &amp; 32</td>
</tr>
<tr>
<td>Loss of Independent Existence</td>
<td>1 &amp; 33</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>1 &amp; 34</td>
</tr>
<tr>
<td>Pericardial Disease</td>
<td>1 &amp; 35</td>
</tr>
<tr>
<td>Pheochromocytoma</td>
<td>1 &amp; 36</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>1 &amp; 37</td>
</tr>
<tr>
<td>Primary Pulmonary Hypertension</td>
<td>1 &amp; 38</td>
</tr>
<tr>
<td>Progressive Scleroderma</td>
<td>1 &amp; 39</td>
</tr>
<tr>
<td>Severe Rheumatoid Arthritis</td>
<td>1 &amp; 40</td>
</tr>
<tr>
<td>Stroke / Brain Aneurysm / Carotid Artery Surgery</td>
<td>1 &amp; 41</td>
</tr>
<tr>
<td>Systemic Lupus Erythematosus with Lupus Nephritis</td>
<td>1 &amp; 42</td>
</tr>
<tr>
<td>Terminal Illness</td>
<td>1 &amp; 43</td>
</tr>
<tr>
<td>Ulcerative Colitis</td>
<td>1 &amp; 44</td>
</tr>
<tr>
<td>Wilson’s Disease</td>
<td>1 &amp; 45</td>
</tr>
</tbody>
</table>

Please enclose copies of Histopathology / Biopsy Report (for Cancer), ECG Reading & Enzymes Assays (for Heart Attack), CT Scan / MRI Scan results (for Stroke and Benign Brain Tumour) and all laboratory and Test results, etc and any relevant hospital reports that are available.

Signature of Attending Doctor:

Name & Qualification:

Address and Official Stamp of Hospital / Clinic:

Date (dd/mm/yyyy):
SECTION 1 : GENERAL INFORMATION

a. Are you the patient’s regular doctor?
   - Yes
   - No
   If Yes, since:
   (dd/mm/yyyy)

b. When did patient first consult you for this illness?
   (dd/mm/yyyy)

c. Please state symptoms presented and the date symptoms first appeared as follows:

<table>
<thead>
<tr>
<th>Symptoms Presented</th>
<th>Date symptoms first started (dd/mm/yyyy)</th>
<th>Duration of symptoms</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>


d. Please provide full and exact details of the diagnosis and its clinical basis.


e. What is the date of diagnosis?
   (dd/mm/yyyy)

f. What is the date when diagnosis was first made known to the patient?
   (dd/mm/yyyy)

g. Has the patient previously suffered from the condition described above or any related illness?
   - Yes
   - No
   If Yes, kindly provide the details below:

<table>
<thead>
<tr>
<th>Illness</th>
<th>Date of First Diagnosis (dd/mm/yyyy)</th>
<th>Name and Address of Attending Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

h. Is there anything in the patient’s personal medical history or family history which would have increased the risk of the above illness? If yes, please give full details including the date of diagnosis and name & address of attending doctor.
   - Yes
   - No

i. Is the patient suffering from other significant illness(es) / condition(s)?
   - Yes
   - No
   If Yes, kindly provide the details below:

<table>
<thead>
<tr>
<th>Illness</th>
<th>Date of First Diagnosis (dd/mm/yyyy)</th>
<th>Name and Address of Attending Doctor</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

j. Please give details of the patient’s past and present smoking habits, including the duration and number of cigarettes smoked per day.

  Signature of Attending Doctor
  Name & Qualification: __________________________

  Address and Official Stamp of Hospital / Clinic
  Date (dd/mm/yyyy): __________________________
### SECTION 2: HEART ATTACK

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>a</strong></td>
<td>Please state the date where Heart Attack was first diagnosed</td>
</tr>
<tr>
<td><strong>b</strong></td>
<td>Was there a current history of chest pain and / or shortness of breath?</td>
</tr>
<tr>
<td><strong>c</strong></td>
<td>Where there any changes in the ECG indicative of a myocardial infarction?</td>
</tr>
<tr>
<td><strong>d</strong></td>
<td>Was there a serial elevation of cardiac enzymes documented?</td>
</tr>
<tr>
<td><strong>e</strong></td>
<td>Was there a death of a portion of the heart muscle?</td>
</tr>
<tr>
<td><strong>f</strong></td>
<td>Was there elevation of Troponin (T or I) documented?</td>
</tr>
<tr>
<td><strong>g</strong></td>
<td>If Yes, please state = Troponin Reading : ___________________ Date : (dd/mm/yyyy)</td>
</tr>
<tr>
<td><strong>h</strong></td>
<td>Was left ventricular ejection fraction (LVEF) taken 3 months or more after the event?</td>
</tr>
<tr>
<td><strong>i</strong></td>
<td>If Yes, please state = LVEF % : ___________________ Date : (dd/mm/yyyy)</td>
</tr>
<tr>
<td><strong>j</strong></td>
<td>Date of return to normal activities : (dd/mm/yyyy)</td>
</tr>
</tbody>
</table>

### SECTION 3: CARDIAC PACEMAKER / DEFIBRILLATOR INSERTION

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>Was pathway ablation therapy attempted?</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>If Yes, please state the date of therapy : (dd/mm/yyyy)</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>If No, please state the reason why this is not done:</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>Was a permanent cardiac pacemaker inserted?</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>If Yes, please state the date of insertion : (dd/mm/yyyy)</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td>Was a permanent cardiac defibrillator inserted?</td>
</tr>
<tr>
<td><strong>G</strong></td>
<td>If Yes, please state the date of insertion : (dd/mm/yyyy)</td>
</tr>
<tr>
<td><strong>H</strong></td>
<td>Was the insertion of cardiac pacemaker / defibrillator absolutely necessary?</td>
</tr>
<tr>
<td><strong>I</strong></td>
<td>Was there any other means to treat the patient’s cardiac arrhythmia?</td>
</tr>
<tr>
<td><strong>J</strong></td>
<td>If Yes, please state the alternative means of treatment:</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>k</strong></td>
<td>If No, please state the reason why the alternative means were not considered:</td>
</tr>
</tbody>
</table>

---

**Signature of Attending Doctor**

Name & Qualification: ________________________________

**Address and Official Stamp of Hospital / Clinic**

Date (dd/mm/yyyy): ________________________________
### SECTION 4: PERICARDIAL DISEASE

A  Please state the date where pericardial disease was first diagnosed  

B  If Yes, please state the nature of surgery performed (e.g. pericardectomy or other keyhole cardiac surgery) and date of surgery:

### SECTION 5: CARDIOMYOPATHY

a  Please state the date where Cardiomyopathy was first diagnosed  

b  Does the patient have any physical impairment which fulfills the New York Heart Association (NYHA) Classification of Cardiac Impairment?  

   - Yes  
   - No  

c  If Yes, please provide details of the physical impairment:

### SECTION 6: HEART VALVE SURGERY

a  What is the date of onset of the heart valve defects?  

b  Was surgery performed to repair or replace the heart valve abnormality?  

   - Yes  
   - No  

c  If Yes, please state the surgical procedure used to correct the valvular problem (i.e. open heart surgery, percutaneous intravascular balloon valvuloplasty with OR without thoracotomy etc)  

d  What was the date of the surgery?  

### Additional Information:

- Is the patient’s condition of Cardiomyopathy related to alcohol misuse?  

   - Yes  
   - No  

- If Yes, please provide details of alcohol consumption, including frequency, amount, duration and types of alcohol:

- Has the patient suffered or is suffering from any related illnesses e.g. hypertension, vascular disease etc:

---

**Signature of Attending Doctor**

Name & Qualification: ________________________________

Date (dd/mm/yyyy): ________________________________

**Address and Official Stamp of Hospital / Clinic**
SECTION 7: CORONARY ARTERY BY-PASS SURGERY / ANGIOPLASTY & OTHER INVASIVE TREATMENT FOR CORONARY ARTERY / OTHER SERIOUS CORONARY ARTERY DISEASE

Please describe the full and exact diagnosis of the heart condition leading to surgery:

Please specify the coronary arteries involved and the percentage of stenosis as shown below:

<table>
<thead>
<tr>
<th>Coronary Artery</th>
<th>Stenosis</th>
<th>Percentage of Stenosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left: Main Stem</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Left: Anterior descending Artery</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Left: Circumflex Artery</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Right: Coronary Artery</td>
<td>Yes / No</td>
<td></td>
</tr>
</tbody>
</table>

Please state the type of surgery performed [i.e. Angioplasty, Coronary Artery By-Pass Surgery, ‘Keyhole’ surgery, Atherectomy, Transmyocardial Laser Revascularisation, Enhanced External Counterpulsation or Minimally Invasive Direct Coronary Artery Bypass (MIDCAB)]

If a Coronary Artery By-Pass surgery was performed:

(1) please state the number of grafts and site of grafts inserted: ________________________________

(2) was open-heart surgery performed?  □ Yes  □ No

(3) what is the date of the surgery?  _____________________ (dd/mm/yyyy)

Please provide the name of surgeon who perform the surgery and the name & address of hospital where the surgery was performed

Has the patient previously suffered from the above illnesses or any other cardiovascular diseases?

Please give details of the patient’s medical history which would have increased the risk of coronary artery disease (eg Hypertension, Hyperlipidaemia, Diabetes)

SECTION 8: SURGERY TO AORTA

On what date did the patient first become aware of the condition necessitating surgery?  _____________________ (dd/mm/yyyy)

What was the type of surgery performed?

When was the surgery performed?  _____________________ (dd/mm/yyyy)

Was excision and surgical replacement of the diseased aorta with a graft performed?  □ Yes  □ No

Was the surgery performed using minimally invasive or intra arterial techniques?  □ Yes  □ No

Was there enlargement of the aorta?  □ Yes  □ No

If Yes, please state the diameter of enlargement in millimetres:

Has the patient suffered or is suffering from any related illnesses e.g. hypertension, angina, vascular disease, endocarditis etc
SECTION 9: STROKE / BRAIN ANEURYSM or CAROTID ARTERY SURGERY

a) Please describe the episode:
   (i) Date of episode
       ___________________________
       (dd/mm/yyyy)
   (ii) Nature of the episode and duration of the acute symptoms:

b) (i) Was there any evidence of neurological deficit 6 weeks after the date of stroke diagnosis?
     Yes ☐ No ☐
     If Yes, please provide details:
     ___________________________
     (dd/mm/yyyy)

   (ii) Are these neurological deficits likely to be permanent?
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

   (iii) Has there been an infarction of brain tissue, haemorrhage or embolisation from an extracranial source?
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

   (iv) Are the investigations or findings consistent with the diagnosis of a NEW stroke?
     Yes ☐ No ☐
     If Yes, please provide details:
     ___________________________
     (dd/mm/yyyy)

c) (i) Is this a Transient Ischaemic Attack?
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

   (ii) Is the brain damage due to an accident or injury, infection, vasculitis or inflammatory disease?
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

   (iii) Is the illness a vascular disease affecting the eye or optic nerve?
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

   (iv) Is the current condition a result of ischaemic disorders of the vestibular system?
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

d) Was an arteriogram carried out? If Yes, please state the date of arteriogram:
     ___________________________
     (dd/mm/yyyy)

e) (i) Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? If Yes, please state the date of surgery:
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

   (ii) Was surgery done via craniotomy?
     Yes ☐ No ☐
     ___________________________
     (dd/mm/yyyy)

f) Was there surgical shunt insertion from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid?
   If Yes, please state the date of insertion:
   ___________________________
   (dd/mm/yyyy)

g) (i) Was there narrowing of the carotid artery?
     If Yes, please state the percentage of narrowing: ___________________________%
     ___________________________
     (dd/mm/yyyy)

   (ii) Was Endarterectomy of the carotid artery absolutely necessary?
     If Yes, please state the actual date where Endarterectomy was performed:
     ___________________________
     (dd/mm/yyyy)
SECTION 10: MAJOR CANCERS / BREAST RECONSTRUCTIVE SURGERY AFTER MASTECTOMY

a Please describe the extent of the disease:
   (i) What is the histological diagnosis of the disease?
   (ii) What is the staging of the Tumour?

b (i) Is the disease completely localized? [ ] Yes [ ] No
   (ii) Was there invasion of adjacent tissues? [ ] Yes [ ] No
   (iii) Were regional lymph nodes involved? [ ] Yes [ ] No
   (iv) Were there distant metastases? [ ] Yes [ ] No

b To be completed ONLY if diagnosis is pre-malignant or non-invasive, skin cancer, prostate cancer, thyroid and bladder cancer or chronic lymphocytic leukaemia:
   (i) Is the condition carcinoma-in-situ? [ ] Yes [ ] No
   (ii) Is the condition Cervical Dysplasia CIN 1, CIN 2 or CIN 3 (severe dysplasia without carcinoma-in-situ)? [ ] Yes [ ] No
   (iii) Is the condition Hyperkeratoses, basal cell and squamous skin cancers? [ ] Yes [ ] No
   (iv) Is the condition melanoma of less than 1.5mm Breslow thickness or less than Clark Level 3? [ ] Yes [ ] No
      If Yes, please provide full details of size, thickness (Breslow thickness) and depth of invasion (Clark Level):
   (v) Is the condition Chronic Lymphocytic Leukaemia classified as lesser than RAI Stage 3? [ ] Yes [ ] No
   (vi) Is the condition Prostate cancer described as TNM classification T1 (i.e. T1a, T1b, T1c) or equivalent or lesser? [ ] Yes [ ] No
   (vii) Is the condition Papillary micro-carcinoma of the Thyroid of less than 1cm size in diameter? [ ] Yes [ ] No
   (viii) Is the condition Papillary micro-carcinoma of the Bladder? [ ] Yes [ ] No
   (ix) Is the tumour in the presence of HIV infection? [ ] Yes [ ] No

c Please provide details of treatment administered (e.g. surgery, chemotherapy, radiotherapy etc)

d When was the surgery performed? ___________________ (dd/mm/yyyy)

f What is the nature of the surgery performed (e.g mastectomy, prostatectomy, gastrectomy)? Please provide the operation report.
   Please specify if there was full or partial resection. For mastectomy, please indicate how many quadrants of the tissue of a breast
   was surgically removed due to the carcinoma-in-situ or a malignant condition.

g Has the patient ever suffered from cancer, malignant, pre-malignant or other related conditions or risk factors?
   If Yes, please provide full details with dates of consultation and the resulting diagnosis:


Signature of Attending Doctor
Name & Qualification: ________________________________________

Address and Official Stamp of Hospital / Clinic
Date (dd/mm/yyyy): ________________________________________

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## SECTION 11: ALZHEIMER’S DISEASE / SEVERE DEMENTIA

### a Please describe the extent of the disease:

1. **(i)** Is there evidence of deterioration or loss of intellectual capacity?  
   - Yes ☐  
   - No ☐

2. **(ii)** Is there abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of patient?  
   - Yes ☐  
   - No ☐

   **If Yes, please describe the behaviour:**

3. **(iii)** Was there permanent clinical loss of the ability to do the following:  
   - Remember ☐  
   - Reason ☐  
   - Perceive, understand, express and give effect to ideas ☐

### b Did the deterioration or loss of intellectual capacity arise from neurosis, psychiatric illnesses or alcohol related brain damage?  

- Yes ☐  
- No ☐

**If Yes, please provide us with the details:**

### c Was there evidence of cognitive impairment for at least 6 months? If Yes, please state the type of cognitive impairments and its duration:

### d Please provide details of any investigations performed including the type of Alzheimer’s test (e.g. Mini-mental exam) and its score:

### e  

1. **(i)** Is the current condition arises from non-organic diseases such as neurosis and psychiatric illnesses?  
   - Yes ☐  
   - No ☐

2. **(ii)** Is the current condition a case of drug or alcohol related brain damage?  
   - Yes ☐  
   - No ☐

### f Was there any memory impairment in the following cognitive areas?  

   - If Yes, please tick the box and state the exact date of onset:

   1. **(i)** Aphasia ☐  
   2. **(ii)** Aproaxia ☐  
   3. **(iii)** Agnosia ☐  
   4. **(iv)** Disturbance in executive functioning ☐

   **Please provide the date of last assessment:**

   1. **(dd/mm/yyyy)**
   2. **(dd/mm/yyyy)**
   3. **(dd/mm/yyyy)**
   4. **(dd/mm/yyyy)**

### g Is the patient currently placed on disease modifying treatment and under your continuous care?  

- Yes ☐  
- No ☐

**If Yes, please provide us with the treatment regime and state the frequency of consultation(s) with your clinic:**

---

**Signature of Attending Doctor**

**Name & Qualification:**

**Address and Official Stamp of Hospital / Clinic**

**Date (dd/mm/yyyy):**

Page 8 of 26
SECTION 12 : APLASTIC ANAEMIA

a Please provide full details of tests and results which have been performed to establish the diagnosis of Aplastic Anaemia

b What is the cause of patient’s aplastic anaemia?
   (i) Acute reversible bone marrow failure
      Yes ☐ No ☐
   (ii) Chronic persistent bone marrow failure
      Yes ☐ No ☐

c Was any of the following present? If yes, please provide us with the relevant laboratory results.
   (i) Anaemia
      Yes ☐ No ☐
   (ii) Neutropenia
      Yes ☐ No ☐
   (iii) Thrombocytopenia
      Yes ☐ No ☐

d What is the nature of treatment?
   (i) Blood product transfusions
      Yes ☐ No ☐
   (ii) Marrow stimulating agents
      Yes ☐ No ☐
   (iii) Immunosuppressive agents
      Yes ☐ No ☐
   (iv) Bone marrow transplantation
      Yes ☐ No ☐

e Is the current condition in any way attributable to HIV infection or AIDS?
   If Yes, please provide us with the details
      Yes ☐ No ☐

SECTION 13 : BACTERIAL MENINGITIS

a Was the diagnosis confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture?
   Yes ☐ No ☐

b Has the patient returned to normal activities?
   If Yes, please provide the date.

   (dd/mm/yyyy)

  Yes ☐ No ☐

c What are the patient’s present limitations, physical and mental?

d Were there any neurological deficit which has lasted for at least 6 weeks?
   Yes ☐ No ☐
   Are these neurological deficits likely to be permanent?
   If Yes, please provide details of the deficits.
   Yes ☐ No ☐

  e Was the condition present due to HIV / AIDS infections?
      Yes ☐ No ☐
### SECTION 14: BENIGN BRAIN TUMOUR

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Has the tumour caused an increase in the intracranial pressure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please provide the detailed location of the tumour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Is the tumour life threatening?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Has the tumour caused damage to the brain?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please provide details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Has the patient undergone surgical removal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please state the type and exact date the surgery was performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Transphenoidal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Transnasal Hypophysectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Open craniotomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. If the surgical removal is not performed, has the tumour caused permanent neurological deficit?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, please provide details of the deficits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Is the patient’s condition a cyst, granuloma, vascular malformation or haematoma?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>g. Is the patient’s tumour in the pituitary gland or spinal cord?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>h. Is the tumour confirmed by imaging studies such as CT scan or MRI?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### SECTION 15: BLINDNESS (LOSS OF SIGHT) / OPTIC NERVE ATROPHY

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. What was the date of onset?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. With the use of visual aids, what is the current visual acuity of both eyes, using the Snellen eye chart?</td>
<td></td>
<td></td>
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<tr>
<td>Left eye:</td>
<td></td>
<td></td>
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<tr>
<td>Right eye:</td>
<td></td>
<td></td>
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<tr>
<td>c. What forms of treatment were rendered?</td>
<td></td>
<td></td>
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<tr>
<td>d. Is the current blindness in both eyes permanent and irreversible?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>e. Will further surgery improve his / her sight?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>If Yes, what kind of surgery will be necessary and what is the tentative date of surgery?</td>
<td></td>
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<tr>
<td>f. Is the condition resulting from alcohol or drug misuse?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes, please provide us with the details.</td>
<td></td>
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</table>

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**Signature of Attending Doctor**

Name & Qualification: ____________________________

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy): ____________________________

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SECTION 16: COMA / SEVERE EPILEPSY

a. What was the date of onset?  

______________________________  (dd/mm/yyyy)

b. How was the diagnosis established? Please include a copy of diagnostic investigation reports (e.g., electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) etc).

c. Was there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for:
   (i) at least 48 hours?  □ Yes □ No
   (ii) at least 72 hours?  □ Yes □ No
   (iii) at least 96 hours?  □ Yes □ No

d. Was there brain damage resulting in permanent neurological deficit?  □ Yes □ No

e. Has the sequelae lasted more than 30 days from the onset of the coma?  □ Yes □ No

f. Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug-serum level testing?  □ Yes □ No
   If Yes, what is the frequency of attack per week?  ____________________  attacks per week


g. Is the patient taking prescribed anti-epileptic (anti-convulsant) medications?  □ Yes □ No
   If Yes, please state the type(s) of medication:

h. Would you consider the patient to be on optimal drug therapy?  □ Yes □ No
   If Yes, please state the type(s) and recommended duration of such therapy:

i. Is the condition resulting from alcohol, drug misuse or medically induced coma?  □ Yes □ No
   If Yes, please provide us with the details.

SECTION 17: DEAFNESS (LOSS OF HEARING)

a. What was the date of onset?  

______________________________  (dd/mm/yyyy)

b. Was the diagnosis confirmed by an audiometric and sound-threshold?  □ Yes □ No

c. Is the loss of hearing considered irreversible?  □ Yes □ No

d. Is there a loss in all frequencies of hearing of:
   (i) at least 60 decibels  □ Yes □ No
   (ii) at least 80 decibels  □ Yes □ No


e. Has the patient undergone surgery to:
   (i) drain cavernous sinus thrombosis  □ Yes □ No
   (ii) insert implant due to permanent damage of cochlea or auditory nerve  □ Yes □ No
   If Yes, please state the actual date of surgery:  ____________________  (dd/mm/yyyy)

Signature of Attending Doctor

Name & Qualification: ______________________________

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy): ____________________
### SECTION 18: ENCEPHALITIS

| a | Was the condition caused by viral infection? | Yes | No |
| b | Was the patient hospitalised? | Yes | No |
|   | If Yes, please provide the exact dates and duration of admission: |
| c | Has the patient returned to normal activities? | Yes | No |
|   | If Yes, please provide the date. |
| d | What are the patient’s present limitations, physical and mental? |
| e | Was there any significant and serious permanent neurological deficit? | Yes | No |
| f | Are the permanent neurological deficits documented for at least 6 weeks? | Yes | No |
| g | Was the condition present due to HIV / AIDS infections? | Yes | No |

### SECTION 19: END STAGE LIVER FAILURE / LIVER DISEASE

| a | Was there end stage liver failure? | Yes | No |
|   | If Yes, please state the date of diagnosis |
| b | Was there evidence of permanent jaundice? | Yes | No |
| c | Was there evidence of ascites? | Yes | No |
| d | Was there evidence of hepatic encephalopathy? | Yes | No |
| e | Was there partial hepatectomy of at least one entire lobe of the liver? | Yes | No |
|   | If Yes, please state the exact date of surgery |
| f | Was there cirrhosis of the liver? | Yes | No |
|   | If Yes, please provide us with the HAI-Knodell Scores together with the liver biopsy result |
| g | What was the cause of the liver failure? |
| h | Was the liver disease secondary to alcohol or drug abuse? | Yes | No |
|   | If Yes, please provide details: |
| i | What is the current condition of the patient and the prognosis? |
SECTION 20: END STAGE LUNG DISEASE / SEVERE ASTHMA

a (i) Has the patient’s lung disease reached end-stage? 
If yes, please state the exact date: 
☐ Yes  ☐ No

(ii) What is the FEV1 test result of the patient?

(iii) Is the patient undergoing extensive and permanent oxygen therapy for hypoxemia? 
☐ Yes  ☐ No

(iv) What is the Arterial blood gas analyses (PaO₂) of the patient?

b (i) Is there evidence of acute attack of severe asthma with persistent status of asthmaticus? 
If yes, please state the exact date and details: 
☐ Yes  ☐ No

(ii) Was the patient hospitalised and required assisted ventilation with a mechanical ventilator for a continuous period of at least 4 hours? 
If Yes, please explain:

☐ Yes  ☐ No

Please provide us with the first and subsequent dates where the patient consulted you for pulmonary emboli:

<table>
<thead>
<tr>
<th>Date</th>
<th>Sign and symptoms</th>
<th>Treatment Provided</th>
<th>Patient’s response to treatment</th>
<th>Name and Address of Attending Doctor</th>
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d Has the patient undergone surgery to:
(i) Insert vena cava filter due to documented proof of recurrent pulmonary emboli 
☐ Yes  ☐ No

(ii) Completely remover of one lung as a result of an accident or an illness
☐ Yes  ☐ No

If Yes, please state the actual date of surgery:

☐ Yes  ☐ No

SECTION 21: POLIOMYELITIS

a i. What was the cause of the disease?

ii. What is the current condition of the patient and what is the prognosis?

iii. Was there paralysis of the limb muscles or respiratory muscles for at least 3 months? 
☐ Yes  ☐ No
### SECTION 22: FULMINANT HEPATITIS / BILIARY TRACT DISEASE

**a**

(i) Please provide full and exact details of the diagnosis including the viru(s) involved.

(ii) What is the approximate date of onset?

(iii) Is there a rapidly decreasing liver size?

(iv) Is there a submassive to massive necrosis of the liver?

(v) Is there a rapidly deterioration of liver function?

(vi) Is there deepening jaundice?

(vii) Is there hepatic encephalopathy?

**b**

(i) Has the patient undergone biliary tract reconstruction surgery involving choledochoenterostomy (choledochojejunostomy or choledochoduodenostomy) for the treatment of biliary tract disease, including biliary atresia?

(ii) Is the biliary tract disease NOT amendable by other surgical or endoscopic measures?

(iii) Is the procedure considered the most appropriate treatment?

(iv) Is patient’s current condition a consequence of gall stone disease or cholangitis?

**c**

(i) Is patient’s condition of chronic primary sclerosing cholangitis confirmed by cholangiogram?

(ii) Is there progressive obliteration of the bile ducts?

(iii) Is there permanent jaundice?

(iv) Is there a need for immunosuppressive treatment, drug therapy for intractable pruritis or balloon dilation or stenting of the bile ducts? If Yes, please provide the details:

(v) Is patient’s current condition a consequence of biliary surgery, gall stone disease, infection, inflammatory bowel disease or other secondary precipitants? If Yes, please provide the details:

**d**

What is the current condition of the patient and what is the prognosis?

---

**Signature of Attending Doctor**

Name & Qualification: __________________________

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy): __________________________
SECTION 23 : HIV DUE TO BLOOD TRANSFUSION & OCCUPATIONALLY ACQUIRED

(a) (i) Was the infection due to:
   ▪ blood transfusion?
   □ Yes □ No
   ▪ organ transplant?
   □ Yes □ No
   ▪ physical or sexual assault?
   □ Yes □ No
(ii) Was the blood transfusion or organ transplant medically necessary or given as part of medical treatment?
   □ Yes □ No
(iii) Did the incident of infection occur in Singapore?
   If Yes, please provide the exact date and details:
   ________________ (dd/mm/yyyy)
   □ Yes □ No

(iv) Was the infection resulted from any other means including sexual activity and the use of intravenous drugs? If Yes, please state the likely cause:
   □ Yes □ No

(v) Was the incident of infection established to involve a definite source of the HIV infected fluids?
   □ Yes □ No

(vi) Was the incident of infection reported to the appropriate authority?
   □ Yes □ No

(vii) Is the Institution where the blood transfusion or organ transplant was performed able to trace the origin of the HIV tainted blood?
   □ Yes □ No

b. Is the patient suffering from Thalassaemia Major or Haemophilia?
   □ Yes □ No

c. Is the occupation of the patient a medical practitioner, houseman, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in Singapore?
   If Yes, please state the actual occupation and name of employer or Institution:

   d (i) Was there an accident whilst the patient was carrying out the normal professional duties of his occupation in Singapore?
   If Yes, please state the date of accident:
   ________________ (dd/mm/yyyy)
   □ Yes □ No

(ii) Was the accident involved a definite source of the HIV infected fluids?
   □ Yes □ No

e (i) Was an HIV antibody test done before the incident of infection?
   If Yes, what was the result?
   □ Yes □ No

(ii) Was an HIV antibody test done after the incident of infection?
   If Yes, what was the result?
   □ Yes □ No
SECTION 24 : KIDNEY FAILURE / CHRONIC KIDNEY DISEASE

a (i) Has the patient’s renal disease reached end-stage? □ Yes □ No
   (ii) Is there chronic renal failure of both kidneys? □ Yes □ No
   (iii) Is the renal failure reversible? □ Yes □ No

b (i) Is the patient undergoing regular peritoneal dialysis or haemodialysis? □ Yes □ No
   If Yes, what was the date of commencement? ____________________ (dd/mm/yyyy)
   (ii) Has renal transplantation been performed? □ Yes □ No
        If Yes, when was it done? ____________________ (dd/mm/yyyy)

   c (i) Was the patient a recipient of the renal transplant? □ Yes □ No
        (ii) Is the renal dialysis / transplantation required as a life-saving procedure? □ Yes □ No
        (iii) Was there decreased renal function of at least eGFR less than 15ml/min/1.73m² body surface? □ Yes □ No
             If Yes, did it persist for a period of at least 6 months and what are the details:

SECTION 25 : LOSS OF SPEECH / PERMANENT TRACHEOSTOMY

a (i) What is the date of onset? ____________________ (dd/mm/yyyy)
   (ii) Is the loss of speech considered total and irrecoverable? □ Yes □ No
   (iii) Has the inability to speak established for a continuous period of 12 months? □ Yes □ No
   (iv) Were there any associated neurological or psychiatric conditions contributing to the patient’s loss of speech? If Yes, please provide details. □ Yes □ No

b What was the cause of the loss of speech?

   c (i) Has tracheostomy been performed? □ Yes □ No
        If Yes, what is purpose of such treatment and when was it done? ____________________ (dd/mm/yyyy)
        (ii) Was tracheostomy performed for treatment of lung or airway disease or as a ventilator support measure following major trauma or burns? □ Yes □ No
             If Yes, please provide the details:
        (iii) Was the patient under the care of medical specialist in a designated intensive care unit (ICU)? □ Yes □ No
             If Yes, how many days was he/she warded in ICU: ____________________
        (iv) Is the tracheostomy required to remain in place and functional for a period of at least 3 months? □ Yes □ No

Signature of Attending Doctor: ____________________________
Name & Qualification: ____________________________
Date (dd/mm/yyyy): ____________________
Address and Official Stamp of Hospital / Clinic: ____________________________

SECTION 26: MAJOR / SEVERE BURNS

a (i) What is the date of onset?  ________________________ (dd/mm/yyyy)

(ii) Please state the areas affected, the percentage of surface area and the degree of burns in each affected area:

<table>
<thead>
<tr>
<th>Area Affected</th>
<th>Percentage of surface area</th>
<th>Degree of burns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(iii) Were there Second Degree (partial thickness of the skin) burns covering at least 20% of the surface of the patient’s body? □ Yes □ No
(iv) Were there Third Degree (full thickness of the skin) burns covering at least 20% of the surface of the patient’s body? □ Yes □ No
(v) Were there Third Degree (full thickness of the skin) burns covering at least 50% of patient’s face or head? □ Yes □ No

b (i) Where and how did the accident happen resulting in the major burns?

(ii) Are the burns self-inflicted? If Yes, please provide details. □ Yes □ No

SECTION 27: MAJOR ORGAN / BONE MARROW TRANSPLANT

a (i) Which of the organ is involved?

(ii) What is the exact date of transplant?  ________________________ (dd/mm/yyyy)

(iii) What is the prognosis?

(iv) Was the transplant resulted from an irreversible end stage failure of the relevant organ? □ Yes □ No

b (i) For bone marrow transplant, is the receipt of transplant from human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation? □ Yes □ No
(ii) For small bowel transplant, is there receipt of at least one meter of small bowel resulting from intestinal failure? □ Yes □ No
(iii) For corneal transplant, is there receipt of a whole cornea due to irreversible scarring with resulting reduced visual acuity which cannot be corrected with other methods? □ Yes □ No
SECTION 28 : MOTOR NEURONE DISEASE / PERIPHERAL NEUROPATHY

a (i) Is there progressive degeneration of:
   ▪ corticospinal tracts;   □ Yes □ No
   ▪ anterior horn cells;   □ Yes □ No
   ▪ bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis   □ Yes □ No

If answer to any of the above is Yes, please provide details:

(ii) Please provide details of the extent of neurological deficits.

(iii) Are the neurological deficits likely to be permanent?   □ Yes □ No

b (i) For peripheral neuropathy, is it arising from anterior horn cells resulting in significant motor weakness, fasciculation and muscle wasting?   □ Yes □ No

(ii) Is the diagnosis evident in nerve conduction studies?   □ Yes □ No

(iii) Is there a permanent need for the use of walking aids or wheelchair?   □ Yes □ No

c (i) Is the current condition arising from diabetic neuropathy?   □ Yes □ No

(ii) Is the neuropathy arising from excessive alcohol consumption?   □ Yes □ No

SECTION 29 : MULTIPLE SCLEROSIS

a i. Is there a history of repeated relapse and remission or a steady progressive disability?   □ Yes □ No

ii. Are there lesions producing well-defined neurological deficits involving the optic nerves, brain stem and spinal cord which occurred over a continuous period of:
   ▪ at least 3 months?   □ Yes □ No
   ▪ at least 6 months?   □ Yes □ No

iii. Are there signs and symptoms of multiple lesions?   □ Yes □ No

iv. Was the neurological damages caused by SLE or HIV / AIDS?
   If Yes, what was the cause?   □ Yes □ No

b Is there a well documented history of exacerbations and remissions of neurological signs?
   If Yes, please provide the details, including dates of each episode:
   □ Yes □ No

   (dd/mm/yyyy)

c Has the patient returned to normal activities?
   If Yes, please provide the date.
   □ Yes □ No

   (dd/mm/yyyy)

d What are the patient’s present limitations, physical and mental?

___________________

Signature of Attending Doctor
Name & Qualification :

Address and Official Stamp of Hospital / Clinic
Date (dd/mm/yyyy) :
SECTION 30: MUSCULAR DYSTROPHY / SPINAL CORD DISEASE

a  (i) Is there any evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex? If Yes, please describe the findings:  
  Yes  No

   (ii) Which are the muscles involved?

b  (i) Was the diagnosis confirmed by an electromyogram?  
  Yes  No

   (ii) Was the diagnosis confirmed by muscle biopsy?  
  Yes  No

c  Is the patient able to perform (whether aided* or unaided) for a continuous period of at least 6 months the followings:

   (i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means  
  Yes  No

   (ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances  
  Yes  No

   (iii) Ability to move from a bed to an upright chair or wheelchair and vice versa  
  Yes  No

   (iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene  
  Yes  No

   (v) Ability to move indoors from room to room on level surfaces  
  Yes  No

   (vi) Ability to feed oneself once food has been prepared and made available  
  Yes  No

* Aided shall mean with the aid of special equipment, device and / or apparatus and not pertaining to human aid

d  (i) For bowel and bladder dysfunction, is there permanent dysfunction requiring permanent regular self catheterisation or permanent urinary conduit?  
  Yes  No

   (ii) Has the bowel and bladder dysfunction lasted for at least 6 months?  
  Yes  No

   If Yes, please provide the exact date of onset:

SECTION 31: PARALYSIS / LOSS OF USE OF ONE LIMB

a  i. When was the date of onset?  

   (dd/mm/yyyy)

   ii. Please state the number and limbs involved?

b  Is there total and irreversible loss of use of at least 1 entire limb?  
  Yes  No

c  Was the paralysis or loss of use of 1 limb due to illness or injury?  

   Please provide details on the cause:

   Yes  No

d  Was the paralysis or loss of use of 1 limb caused by self-inflicted injuries?  

   If Yes, please provide details:

   Yes  No
### SECTION 32 : PARKINSON’S DISEASE

**a** (i) What is the cause of the disease?

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**b** (i) Can the condition be controlled with medication?

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(ii) If Yes, please provide details and exact date where medication was commenced:

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(iii) Are there signs of progressive impairment?

If Yes, please provide details:

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(iv) Did Parkinson’s Disease result from treatment for any other illness, or is it associated with any other disease e.g. Wilson’s Disease or Huntington’s Chorea?

If Yes, please provide details:

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<th>Yes</th>
<th>No</th>
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**c** Is the patient able to perform (whether aided* or unaided) for a continuous period of at least 6 months the followings:

(i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means

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<th>Yes</th>
<th>No</th>
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(ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances

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(iii) Ability to move from a bed to an upright chair or wheelchair and vice versa

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(iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene

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(v) Ability to move indoors from room to room on level surfaces

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<th>Yes</th>
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(vi) Ability to feed oneself once food has been prepared and made available

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<th>Yes</th>
<th>No</th>
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* Aided shall mean with the aid of special equipment, device and / or apparatus and not pertaining to human aid

**d** (i) Is the Parkinsonism due to:

- drug induced cause
- toxic cause

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<th>Yes</th>
<th>No</th>
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</table>
### SECTION 33: PRIMARY PULMONARY HYPERTENSION

a (i) Was there a dyspnoea and fatigue?  
   - Yes  
   - No  

(ii) Is the pulmonary hypertension due to primary cause?  
   - Yes  
   - No  

(iii) Is the pulmonary hypertension due to secondary cause?  
   - Yes  
   - No  

(iv) Is there presence of right ventricular hypertrophy, dilation and signs of right heart failure and decompensation?  
   - Yes  
   - No  

(v) Was cardiac catheterization carried out to establish the pulmonary hypertension?  
   - Yes  
   - No  

b Was the patient able to engage in any physical activity without discomfort?  
   - Yes  
   - No  

c Are the symptoms present even at rest?  
   - Yes  
   - No  

d Was there permanent physical impairment which fulfills the the NYHA classification of cardiac impairment?  
   - Yes  
   - No  

   **NYHA Class:**  
   - I  
   - II  
   - III  
   - IV  

### SECTION 34: SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS

a (i) Does patient’s current condition requires systemic immunosuppressive therapy due to involvement of multiple organ?  
   - Yes  
   - No  

   If Yes, please state the exact commencement date of the therapy:  
   - (dd/mm/yyyy)  

(ii) Are the following internal organs involved:  
   - Yes  
   - No  

   - kidneys  
   - brain  
   - heart or pericardium  
   - lungs or pleura  
   - joints in the presence of polyarticular inflammatory arthritis  

b (i) Was renal biopsy performed?  
   - Yes  
   - No  

   If Yes, please state the exact date biopsy was done:  
   - (dd/mm/yyyy)  

(ii) Are both kidneys involved?  
   - Yes  
   - No  

   If Yes, please state the class of Lupus Nephritis in accordance with WHO classification:  
   - Lupus Nephritis Class:  
   - I  
   - II  
   - III  
   - IV  

c (i) Were there discoid lupus and or those forms with haematological involvement?  
   - Yes  
   - No
### SECTION 35: DIABETIC COMPLICATIONS

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<tr>
<td>a (i)</td>
<td>What is the cause of gangrene?</td>
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<td>b (i)</td>
<td>For diabetic retinopathy, does patient require to undergo laser treatment?</td>
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<td></td>
<td>Yes</td>
<td>No</td>
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<td>For fluorescent Fundus Angiography performed?</td>
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<td>If Yes, please state the exact date it was done:</td>
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<td>(dd/mm/yyyy)</td>
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<td>Is patient’s vision measured at 6/18 or worse in the better eye using a Snellen eye chart?</td>
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<td>If Yes, please state the actual reading of the better eye and date the measurement was done:</td>
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<td></td>
<td>Reading of better eye:</td>
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<td></td>
<td>(dd/mm/yyyy)</td>
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<tr>
<td>c (i)</td>
<td>For diabetic nephropathy, is there evidence of eGFR at less than 30 ml/min or 1.73 m²?</td>
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<td></td>
<td>If Yes, please state the exact bone density reading was done:</td>
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<td></td>
<td>(dd/mm/yyyy)</td>
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<td></td>
<td>Is there ongoing proteinuria greater than 300mg/24 hours?</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>d (i)</td>
<td>Was there actual undergoing of foot / toe / hand / finger amputation?</td>
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<td>If Yes, please state the exact date and body part that was amputated:</td>
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<td></td>
<td>Amputation of: foot / toe / hand / finger (please circle the affected area):</td>
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<td></td>
<td>(dd/mm/yyyy)</td>
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<td>Yes</td>
<td>No</td>
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<td>Yes</td>
<td>No</td>
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<td>Yes</td>
<td>No</td>
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</table>
SECTION 37 : SEVERE RHEUMATOID ARTHRITIS

a (i) Was there widespread joint destruction with major clinical deformity of the following joint areas:
- knees / ankles / feet (please circle the affected area)
- spine

b (i) Was the diagnosis supported by all of the following:
- morning stiffness
- symmetric arthritis
- presence of rheumatoid nodules
- elevated titres of rheumatoid factors
- radiographic evidence of severe involvement

(ii) If answers to the above are Yes, please state the exact date of commencement and the date where the diagnostic test(s) were performed:

___________________ (dd/mm/yyyy)

SECTION 38 : DENGUE HAEMORRHAGIC FEVER

a (i) Was there history of continuous high fever for two or more days?

(ii) Was there minor or major haemorrhagic manifestations?

(iii) Was there thrombocytopenia of less than or equal to 100,000 per mm³?

(iv) Was there haemoconcentration (haematocrit increased by 20% or more)?

(v) Was there evidence of plasma leakage i.e. pleural effusion, ascites or hypoproteinaemia etc?

(vi) Was there evidence of Dengue Shock Syndrome (DSS) with:
- hypotension less than 80 mm Hg or narrow pulse pressure of 20 mm Hg or less?
- tissue hypoperfusion such as cold, clammy skin, oliguria or metabolic acidosis?

b (i) Was there unequivocal evidence of DSS stage 3 or Stage 4 as defined by WHO with confirmatory serological testing?

If Yes, please state the stage and exact date of serological test performed:
DSS Stage: __________________

___________________ (dd/mm/yyyy)

SECTION 39 : TERMINAL ILLNESS

a What is the diagnosis and prognosis of patient’s illness?

b In your opinion, is the condition highly likely to lead to death within 12 months?
If Yes, please provide your basis.

___________________

___________________ (dd/mm/yyyy)

___________________

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy):

<table>
<thead>
<tr>
<th>SECTION 40 : MAJOR HEAD TRAUMA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a (i) What is the date of accident?</strong></td>
</tr>
<tr>
<td>(dd/mm/yyyy)</td>
</tr>
<tr>
<td><strong>b (i) Where and how did the accident happen resulting in the major head trauma?</strong></td>
</tr>
<tr>
<td><strong>(ii) Did the injury result from a self-inflicted act?</strong></td>
</tr>
<tr>
<td>If Yes, please provide details.</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>(iii) Was there reason to suspect that there were contributory circumstances which led to the injury, e.g. under the influence of alcohol, drugs, etc?</strong></td>
</tr>
<tr>
<td>If Yes, please provide details.</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>(iv) Was there a police report made with regard to this accident?</strong></td>
</tr>
<tr>
<td>If Yes, please provide a copy of the police report (if available).</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>c (i) Was there any form of neurological deficit still present 6 weeks after the date of accident?</strong></td>
</tr>
<tr>
<td>If Yes, please state the neurological deficit(s).</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>(ii) Is this neurological deficit likely to be permanent?</strong></td>
</tr>
<tr>
<td>If No, please state the date of recovery or date which the patient is expected to recover from the neurological deficit.</td>
</tr>
<tr>
<td>(dd/mm/yyyy)</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>d (i) Did the patient undergo open craniotomy for treatment of depressed skull fracture or major intracranial injury?</strong></td>
</tr>
<tr>
<td>If Yes, please provide details and attach a copy of the surgery note.</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>(ii) If the patient had suffered from facial injury, was there any reconstructive surgery above the neck to correct disfigurement (restoration or reconstructive of the shape and appearance of facial structures which are defective, missing or damaged or misshapened)?</strong></td>
</tr>
<tr>
<td>If Yes, please provide details of the surgery performed.</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>e (i) Is the patient mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)?</strong></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td><strong>f To be completed ONLY if the patient had accidental cervical spinal cord injury:</strong></td>
</tr>
<tr>
<td><strong>(i) Has the accidental cervical spinal cord injury resulted in the loss of use of at least one entire limb for at least 6 weeks from the accident?</strong></td>
</tr>
<tr>
<td>If Yes, please provide details.</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
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</tbody>
</table>
SECTION 41 : PROGRESSIVE SCLERODERMA

a Please provide a description of the extent of the illness.

b Does the illness involve the followings:

(i) skin with deposits of calcium (calcinosi)  
   □ Yes □ No

(ii) skin thickening of the fingers or toes (sclerodactyly)  
    □ Yes □ No

(iii) the esophagus  
     □ Yes □ No

(iv) telangiectasia (dilated capillaries) and Raynaud’s Phenomenon causing artery spasms in the extremities  
     □ Yes □ No

(v) heart  
    □ Yes □ No

(vi) lungs  
     □ Yes □ No

(vii) kidneys  
      □ Yes □ No

c Please provide the results of investigations done and attach copy of the serology and biopsy report (if any)

SECTION 42 : APALLIC SYNDROME

a Is there presence of universal necrosis of the brain cortex with the brainstem intact?  
   If Yes, describe the neurological damage.  
   □ Yes □ No

b Did the appallic syndrome persist for at least one month since its onset?  
   If Yes, please state the duration for which it persisted:  
   □ Yes □ No

c Is the patient’s condition in any way related or due to AIDS or HIV related illness?  
   If Yes, please provide details.  
   □ Yes □ No

SECTION 43 : LOSS OF INDEPENDENT EXISTENCE

a Is the patient able to perform (whether aided* or unaided) for a continuous period of at least 6 months the followings:

(i) Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means  
    □ Yes □ No

(ii) Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances  
     □ Yes □ No

(iii) Ability to move from a bed to an upright chair or wheelchair and vice versa  
     □ Yes □ No

(iv) Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene  
     □ Yes □ No

(v) Ability to move indoors from room to room on level surfaces  
    □ Yes □ No

(vi) Ability to feed oneself once food has been prepared and made available  
     □ Yes □ No

* Aided shall mean with the aid of special equipment, device and / or apparatus and not pertaining to human aid

Signature of Attending Doctor
Name & Qualification:

Address and Official Stamp of Hospital / Clinic
Date (dd/mm/yyyy): 

Page 25 of 26
**SECTION 44 : CROHN’S DISEASE**

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<tr>
<td>a</td>
<td>Is there evidence of continued inflammation of the bowel in spite of optimal therapy?</td>
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<tr>
<td>b</td>
<td>Has any of the following occurred?</td>
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<tr>
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<td>(i) stricture formation causing intestinal obstruction requiring admission to hospital?</td>
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<td>(ii) fistula formation between loops of bowel</td>
</tr>
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<td></td>
<td>(iii) resection of at least one bowel segment</td>
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<tr>
<td>c</td>
<td>Please provide results of investigations done and attach copy of the pathology report (if any)</td>
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**SECTION 45 : ULCERATIVE COLITIS**

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<tr>
<td>a</td>
<td>Please provide a description of the extent of the illness.</td>
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<td>b</td>
<td>Does the illness involve the followings:</td>
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<tr>
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<td>(i) life threatening electrolyte disturbances usually associated with intestinal distensions and a risk of intestinal rupture</td>
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<td>(ii) entire colon with severe bloody diarrhoea and systemic signs and symptoms</td>
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<td>(iii) total colectomy and ileostomy</td>
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<tr>
<td>c</td>
<td>Please provide the results of investigations done and attach copy of the biopsy report (if any)</td>
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**SECTION 46 : PHEOCHROMOCYTOMA**

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<td>a</td>
<td>Please provide a description of the extent of the illness.</td>
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<td>b</td>
<td>Was there secretion of excess catecholamines?</td>
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<td>c</td>
<td>Please provide the results of investigations done and attach copy of the biopsy report (if any)</td>
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**SECTION 47 : WILSON’S DISEASE**

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<tr>
<td>a</td>
<td>Please provide a description of the extent of the illness.</td>
</tr>
<tr>
<td>b</td>
<td>Does the illness involve the followings:</td>
</tr>
<tr>
<td></td>
<td>(i) a progressive liver disease</td>
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<tr>
<td></td>
<td>(ii) neurologic deterioration due to copper deposit</td>
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<tr>
<td>c</td>
<td>Please provide the results of investigations done and attach copy of the biopsy report (if any)</td>
</tr>
</tbody>
</table>
DECLARATION OF BENEFICIAL OWNERSHIP

Is there a beneficial owner in receiving this payment?  □ Yes  □ No

If Yes, please provide the particulars of the beneficial owner(s) to this policy and submit a copy of their NRIC / Passport (certified by your servicing adviser) to us.

Name(s) :

NRIC / Passport No(s) :

Address(es) :

Contact No(s) :   (H)    (O)    (HP)

Relationship to Deceased :

Nationality:  □ Singaporean  □ Singaporean PR  □ Others, please specify ______________________

Note: Beneficial owner, in relation to a customer of a financial adviser, means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over body corporate or unincorporated.

__________________________________________

Signature of Claimant

Date :   (dd/mm/yyyy)

Name(s) :

NRIC No(s) :

Address(es) :

Contact No(s) :   (HP)

Relationship :   ____________________________________________________________
AUTHORIZATION FORM FOR MEDICAL REPORT

NAME OF PATIENT : ____________________________
NRIC NO. : ___________________ POLICY NO. : _____________

This consent form is required for an insurance claim.

Authorization
I / We hereby authorize:
(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd. ("Company"), any relevant information concerning the above-named patient, and;

(b) the Company release to any medical source, insurance office, or organization, any relevant information concerning the above-named patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

______________________________
Signature of *Patient / Patient’s Parent / Guardian

Name : ____________________________
Address : ___________________________

NRIC No. : ___________________ Relationship to patient : _____________

* If the patient is below 21 years old, this form should be signed by the patient’s parent / guardian