



* Please delete where appropriate

[illegible]

08/2024

(f) Actual Diagnosis: _____

(g) Date when Life Assured first became aware of this illness:

Day		Month		Year	

(h) Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse?
If "YES", please give details.

YES / NO*

3. (a) What is the staging of the tumour?

(b) Please state the tumour classification (e.g. TNM classification etc).

(c) Please confirm the following:-

- (i) Was the cancer completely localised?
- (ii) Was there invasion of tissues?
- (iii) Were regional lymph nodes involved?
- (iv) Were there distant metastases?

YES / NO*

YES / NO*

YES / NO*

YES / NO*

4. (a) Did the Life Assured undergo any surgery

YES / NO*

If "YES", state date of surgery:

Day		Month		Year	

If "YES", please indicate the surgical procedure performed.

(b) Was there any other mode of treatment, other than surgery, which could be undertaken to treat the Life Assured's condition?

YES / NO*

If "YES", please specify type of treatment?

Date

Signature of Doctor

(c) Has the Life Assured underwent other mode of treatment?

YES / NO*

If "YES", please state the date of treatment.

Day		Month		Year	

If "NO", why not?

5. What other forms of treatment did the Life Assured undergo (e.g. chemotherapy, radiotherapy etc.)?

6. If diagnosis is leukaemia, please provide the type of leukaemia.

7. If the diagnosis is malignant melanoma, please give full details of size, thickness (Breslow classification) and/or depth of invasion (Clark level).

8. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?

YES / NO*

If "YES", please provide the date of diagnosis for HIV / AIDS?

Day		Month		Year	

9. (a) Please describe the Life Assured's mental and cognitive abilities.

(b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)?

YES / NO*

Date

Signature of Doctor

10. Does the Life Assured have any other medical conditions? YES / NO*

If "YES", please state medical condition, date of diagnosis and name & address of treating doctor.

Medical Conditions	Diagnosis Date (DD/MM/YYYY)	Name and Address of Doctor who treated Life Assured

11. Does the Life Assured have any family history? YES / NO*

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

Relationship to the Life Assured	Nature of Condition	Age of Onset

12. Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

13. Please give details of the Life Assured's habit in relation to alcohol consumption including the amount of alcohol consumption per day and source of information.

14. Please provide any other information which may be of assistance to us in assessing this claim.

Date

Signature & Official Stamp of Doctor