CHUBB®

Living Benefit Claim - Stroke
Part II - Attending Physician's Statement
(to be completed by attending physician at the claimant's own expenses)

Policy no. | | | | | | | | | | |

Patient's name	HKID Card/Passport no.	Date of birth DD MM YYYY / /	Sex	Age

Stroke

Any cerebrovascular incident producing neurological sequelae lasting more than twenty-four (24) hours and including infarction of brain tissue, haemorrhage and embolisation from an extracranial source. Evidence of permanent neurological damage must be confirmed by a Specialist in neurology at the earliest six (6) weeks after the incident and no claims can be admitted earlier. Cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve as well as ischaemic disorders of the vestibular system are excluded.

A. General Information

1. Are you the patient's usual doctor? ☐ Yes ☐ No
   Since when (/ /) DD MM YYYY

2. When were you first consulted for this illness?
   (/ /) DD MM YYYY

3. What were the presenting symptoms?

4. According to the patient, how long had the symptoms been present?
   Since (/ /) DD MM YYYY **OR** for: years months days

5. What were the significant physical findings?

6. What was the exact diagnosis?

7. Date of diagnosis made?
   (/ /) DD MM YYYY

8. When was the patient informed of the diagnosis? (Please give exact date)
   (/ /) DD MM YYYY

9. If you are not the first who diagnosed for this illness, please give name and address of the doctor who informed the patient of the diagnosis.
   Doctor's name and address

10. Other physicians or medical facilities the patient has consulted for this condition.

Name of physician(s) &/or hospital(s)	Address(es)	Date of consultation(s) &/or period of confinement DD MM YYYY
		(/ /) To (/ /)
		(/ /) To (/ /)
		(/ /) To (/ /)

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B. Extent of Illness

1. Has the Insured previously suffered from any related illness (eg hypertension, transient ischaemic attack, angina or other vascular disease)? If yes, please give dates of consultations and the exact diagnosis.

2. Were there any infarction of brain tissue, haemorrhage and embolisation from an extra-cranial source?

3. Please comment any neurological sequelae, which lasted more than 24 hours.

4. a. Are the neurological damages described above permanent?

   b. If (a) is 'Yes', when and by whom are the neurological damages confirmed to be permanent?

   c. If (a) is 'No', please give date of returning to normal activities and the Insured's present limitation - both physically and mentally.

5. Is the condition of the Insured
   a. Cerebral symptom due to migraine?

   b. Cerebral injury resulting from trauma or hypoxia?

   c. Vascular disease affecting eye or optic nerve?

   d. Ischaemic disorders of the vestibular system?

6. Please supply details of radiological, CT scanning or NM imaging, and laboratory evidence as well as any other tests. Please provide copies of relevant hospital reports that are available

7. What is the prognosis of the disease?

C. Other Information

1. Does the patient smoke cigarette or drink alcohol? If yes, please give details including the daily consumption and the duration of the habit.
   ☐ Yes ☐ No
   Quantity Type Duration

2. Please state if the patient has suffered / been treated for any other illness(es) / complaints other than this critical illness.

3. Is there any further information, which in your opinion will assist us in assessing this claim?

I hereby certify that I have personally examined and treated the patient for the above illness and that the facts as given above present my opinion of his/her conditions.

Name of physician (with stamp)	Qualification	Signature	Date

Address: _____

_____ Tel no.: _____

Chubb. Insured.℠