CHUBB®

Living Benefit Claim - Bacterial Meningitis
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

Bacterial Meningitis

A confirmed diagnosis of bacterial meningitis causing inflammation of the membranes of the spinal cord or brain and resulting in permanent neurological deficit persisting for at least six (6) consecutive months as proven to our satisfaction by a Specialist in neurology.

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 (/ /)

B. Extent of Illness

1. Please provide full and exact details of the diagnosis.

2. Etiology

3. The site of the meningitis involved
   ☐ Membranes of the brain
   ☐ Spinal cord
   ☐ Others

4. Investigations done (dates, procedures, results)

Date	Procedure	Result

Note: Please enclose copies of all reports, including biopsy reports, cytology reports, x-rays, CT scans, other imaging studies, laboratory evidence, surgical report, etc. and any relevant hospital reports that are available.

5. Is there any significant and serious neurological deficit resulted? ☐ Yes ☐ No
   If 'Yes', please give details of the deficit and state how long it has been documented

   Is the deficit expected to be permanent? ☐ Yes ☐ No

6. What is the nature of treatment?

7. What is the prognosis of the disease?

8. Is the disease diagnosed to be directly or indirectly caused by or resulted from.
   ☐ Self-inflicted injuries while sane or insane
   ☐ AIDS, AIDS-related complex or infection by HIV
   ☐ Willful misuse of any alcohol, narcotic or drug
   Please give details if any of the above item(s) is/are applicable.

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.: _____

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