Critical Illness

Claim Form

SG020

CHUBB®

Important Notes

This claim form is to facilitate your claim in the event of you or a member of your family is confined to hospital while being Insured under a Personal Accident policy.

You can help to avoid unnecessary delay in processing your claim by ensuring that:

1) Sections A to F are fully completed and signed by the Insured and/or claimant..

2) Attached Attending Physician's Report is duly completed and signed by the Attending Physician. Please bring along or attached a copy of the relevant policy definition for the Attending Physician reference.

3) Please note that you or the claimant is responsible for any expenses incurred in obtaining medical evidence in support of the claim.

The issue and acceptance of this form and its accompanying documents (if any) does NOT constitute an admission by Chubb Insurance Singapore Limited (Chubb) that any part or the whole of the Claimant's claim is accepted. It also does not constitute a waiver of Chubb's rights in accordance with the terms and conditions of the Policy.

Section A: Particulars of Policyholder / Insured Person

Name of Policyholder / Insured Person (as shown in NRIC / Passport)

_____

Address of Policyholder / Insured Person

_____

_____ Postal Code_____

Policy No (s)

_____

Tel No. (Mobile) _____ Tel No. (Residence) _____

Tel No. (Office) _____ NRIC / Passport No. _____

Date of Birth DD / MM / YYYY Age _____

Gender ☐ Male ☐ Female Nationality _____

Email _____

Occupation _____ Date of Employment DD / MM / YYYY

Name of Employer _____

Name of Claimant (as shown in NRIC / Passport) - if different from Policyholder / Insured Person

_____

NRIC / Passport No. _____ Nationality _____

Date of Birth DD / MM / YYYY Relationship to Insured Person _____

Gender ☐ Male ☐ Female Age _____

Occupation / Industry of Business

_____

Name of Employer _____

Section B: Payment Details

Please provide details for payment of your claim in the event that the claim is deemed payable by Chubb.

I/We hereby authorise and request Chubb to pay benefit due in respect of this claim as follows (Name as per Identification Card and / or Bank Account):

☐ Cheque Payment

Payee Name (as per bank account name) _____

☐ Electronic Funds Transfer (for payments in SGD and to bank accounts in Singapore)

Payee Name (as per bank account name) _____

Name of Bank _____

Branch Code No. _____ Account No. _____

If no name is provided, settlement will be effected to the payee as provided for under the terms of the policy.

Section C: Details of Illness

1. Date of symptoms first noticed DD / MM / YYYY

2. Date of first consultation with a medical practitioner for this condition DD / MM / YYYY

3. Nature of Illness. Describe the symptoms suffered

_____

_____

_____

_____

_____

_____

4. Has the claimant ever seen a doctor for any similar condition in the past? ☐ Yes ☐ No
If **Yes**, please provide details:

Name of Clinic / Hospital _____

Address _____

Name of Attending Physician _____

Tel No. _____ Fax _____

5. Name of Hospital _____

6. Period of Hospitalisation

a. From DD / MM / YYYY To DD / MM / YYYY

b. From DD / MM / YYYY To DD / MM / YYYY

c. From DD / MM / YYYY To DD / MM / YYYY

7. If claimant is/was hospitalised outside of Singapore, please advise:

a) Claimant's Address when Overseas

_____

_____

b) Purpose of Overseas Trip _____

c) Duration of Overseas Trip _____ days

d) Please state the Name and Address of Hospital, usual Attending Physician, and Telephone and Fax number of the hospital

_____

_____

_____

_____

_____

_____

Section D: Any Other Insurances

Are you claiming from any other insurance company or other sources in respect of this condition? ☐ Yes ☐ No
If **Yes**, please state:

Name of Insurance Company	Policy No.	Amount of Benefits	Date Insurance Effected

Section E: General Details

Have any of your blood relatives suffered from a similar or related illness? ☐ Yes ☐ No
If **Yes**, please provide the full details.

Relationship of Kin	Nature of Illness	Date of Diagnosis

Section F: Declaration

Did you remember to enclose the following? (Where applicable)

Document	Yes	NA
Written notes from Physician on type of injury sustained / Inpatient Discharge Summary or Medical Report	☐	☐
Original Medical Bills	☐	☐
Copy of Medical Certificates	☐	☐

By signing this form, I / We agree that Chubb Insurance Singapore Limited (Chubb) will use the information supplied here and during the formation and performance of the policy, for policy administration, customer services, claims handling and fraud analysis and prevention, and that Chubb may disclose such information to its service providers, agents, authorities and other parties for these purposes.

I / We hereby authorise any hospital, physician, and any other person or entity who has attended to or examined the insured, to furnish to Chubb or its authorised representatives, any and all information with respect to any illness or injury or loss, medical history, consultation, prescriptions or treatment, copies of all hospital, medical or other records, investigation status and results, and such personal information as Chubb in its absolute discretion considers relevant for its assessment of this claim. A photostatic copy of this authorisation shall be considered as effective and valid as the original.

I / We do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I / we agree that if I / we have made or in any further declaration or representation in respect shall make any false or fraudulent statements or suppress, conceal or falsely state any fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims shall be forfeited.

_____

Signature of Policyholder
(Please affix company stamp if applicable)

_____

Date

_____

Signature of Claimant
(if different from Policyholder)

_____

Date

Note:

Kindly submit the completed claim form in person or by mail to Chubb Insurance Singapore Limited at 138 Market Street #11-01 CapitaGreen Singapore 048946. Please ensure that the relevant original copies of supporting documents are submitted as well.

Contact Us

Chubb Insurance Singapore Limited
Co Regn. No.: 199702449H
138 Market Street
#11-01 CapitaGreen
Singapore 048946
O +65 6398 8000
F +65 6298 1055
www.chubb.com/sg

Critical Illness

Claimant's Attending Physician's Report

The issue and acceptance of this form does NOT constitute an admission of liability by Chubb Insurance Singapore Limited (Chubb) or waiver of its rights.

Name of Claimant (as shown in NRIC/Passport)

_____

NRIC / Passport No. _____

This Claimant has submitted a claim in relation to the following illness. (Please tick [✔] in the appropriate box and complete the relevant sections)

Critical Conditions	Sections to be Completed
1. Amyotrophic Lateral Sclerosis	☐ 1, 2, 3, 34 and 35
2. Aplastic Anaemia	☐ 1, 2, 4, 34 and 35
3. Bacterial Meningitis	☐ 1, 2, 5, 34 and 35
4. Benign Brain Tumour	☐ 1, 2, 6, 34 and 35
5. Blindness	☐ 1, 2, 7, 34 and 35
6. Cancer	☐ 1, 2, 8, 34 and 35
7. Coma	☐ 1, 2, 9, 34 and 35
8. Coronary Artery Bypass Surgery	☐ 1, 2, 10, 34 and 35
9. Fulminant Viral Hepatitis	☐ 1, 2, 11, 34 and 35
10. Heart Valve Replacement	☐ 1, 2, 12, 34 and 35
11. Kidney Failure	☐ 1, 2, 13, 34 and 35
12. Liver Failure	☐ 1, 2, 14, 34 and 35
13. Loss of Hearing	☐ 1, 2, 15, 34 and 35
14. Loss of Limbs	☐ 1, 2, 16, 34 and 35
15. Loss of Speech	☐ 1, 2, 17, 34 and 35
16. Major Burns	☐ 1, 2, 18, 34 and 35
17. Major Organ Transplantation	☐ 1, 2, 19, 34 and 35
18. Motor Neuron Disease	☐ 1, 2, 20, 34 and 35
19. Muscular Dystrophy	☐ 1, 2, 21, 34 and 35
20. Myocardial Infarction	☐ 1, 2, 22, 34 and 35
21. Paralysis	☐ 1, 2, 23, 34 and 35
22. Parkinson's Disease	☐ 1, 2, 24, 34 and 35
23. Poliomyelitis	☐ 1, 2, 25, 34 and 35
24. Primary Pulmonary Arterial Hypertension	☐ 1, 2, 26, 34 and 35
25. Progressive Bulbar Palsy	☐ 1, 2, 27, 34 and 35
26. Progressive Muscular Atrophy	☐ 1, 2, 28, 34 and 35
27. Severe Brain Damage	☐ 1, 2, 29, 34 and 35
28. Stroke	☐ 1, 2, 30, 34 and 35
29. Surgery to Aorta	☐ 1, 2, 31, 34 and 35
30. Terminal Illness	☐ 1, 2, 32, 34 and 35
31. Total and Permanent Disability	☐ 1, 2, 33, 34 and 35

Section 1: General Information

1. Are you the Claimant's usual medical physician? ☐ Yes ☐ No
   If yes, do you keep full record of all his consultations? ☐ Yes ☐ No
2. When were you first consulted for this illness? DD / MM / YYYY
3. What were the symptoms complained by the Claimant?

   _____

   _____

4. For how long had the Claimant been experiencing these symptoms?

5. For how long do you think these symptoms had lasted?

6. What is the diagnosis?

7. When was the diagnosis made? DD / MM / YYYY

   When was the Claimant first aware of the diagnosis? DD / MM / YYYY

8. Is this diagnosis related to any previous illnesses? ☐ Yes ☐ No
   If yes, please give dates of consultation and the illnesses being diagnosed.

9. If a surgery is performed, when was it carried out? DD / MM / YYYY

10. Is there any factor(s) such as the Claimant's family medical history which would have increased the risk of the Claimant's illness? ☐ Yes ☐ No
    If yes, please provide details on the family medical history.

Section 2: Details of Diagnosis

1. Please provide full and exact details of the diagnosis and its clinical records.

Section 3: Amyotrophic Lateral Sclerosis

Definition: Amyotrophic Lateral Sclerosis means unequivocal diagnosis by a consultant neurologist confirming well defined neurological deficit with persistent signs of involvement of the spinal nerve columns and the motor centres in the brain and with specific weakness and atrophy of the muscles of the extremities.

1. How is the diagnosis made and by whom?

_____

_____

2. Please describe the permanent neurological deficit.

_____

_____

3. Is there involvement of spinal column and motor centre of the brain? ☐ Yes ☐ No
4. Is there atrophy of muscles of the extremities? ☐ Yes ☐ No

Please provide a copy of each investigation result and laboratory evidence including (but not limited to) X-rays, CT scans, MRI etc.

Section 4: Aplastic Anaemia

Definition: Aplastic Anaemia means chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

i. blood product transfusion;
ii. immunosuppressive agents; or
iii. bone marrow transplantation.

1. Please describe the extent of the disease.

_____

_____

2. Please provide details on the following.

Hemoglobin level _____ White cell count _____

Red cell count _____ Platelet count _____

3. What is the nature of treatment?

a) Blood product transfusion ☐ Yes ☐ No

b) Immunosuppressive agents ☐ Yes ☐ No

c) Bone marrow transplantation ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedures, CT scans, other imaging procedures etc.

Section 5: Bacterial Meningitis

Definition: Bacterial Meningitis means bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit persisting for at least six (6) consecutive months, such diagnosis to be confirmed by a licensed consultant neurologist.

1. Please specify is there any underlying cause/predisposition e.g. Diabetes, Cancer, HIV leading to this disease.

_____

_____

2. Has the Claimant returned to normal activities? ☐ Yes ☐ No
   If yes, please advise the date of return DD / MM / YYYY

3. What are the patient's present limitations, both physical and mental?

_____

_____

_____

_____

4. Were there any neurological deficit which lasted for more than 3 months? ☐ Yes ☐ No

5. If yes, what are the neurological deficits?

_____

_____

6. Are these neurological deficits permanent? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedures, CT scans, other imaging procedures, CSF culture etc.

Section 6: Benign Brain Tumour

Definition: Benign Brain Tumour means a non-cancerous tumour in the brain which either requires surgical excision or causes significant permanent neurological deficit persisting for at least six (6) consecutive months. For the avoidance of doubt, the following shall not fall within the definition of Benign Brain Tumour and are not covered under this Policy:

i. cysts, granulomas, malformations in, or of the arteries or veins of the brain; or
ii. hematomas and tumours in the pituitary gland or spine.

1. Please describe the extent and nature of the Benign Brain Tumour.

   a) Was surgical excision performed? ☐ Yes ☐ No

   b) Are there any significant permanent neurological deficit? ☐ Yes ☐ No

   c) Please provide the detailed location of the tumour.

_____

_____

_____

_____

2. Is the tumour in the brain confirmed by imaging studies such as CT Scan or MRI? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedures, CT scans, other imaging procedures etc.

Section 7: Blindness

Definition: Blindness means total and irrecoverable loss of all sight of both eyes due to injury or disease. The diagnosis must be clinically confirmed by a licensed medical specialist.

1. What is the cause of Blindness?

_____

_____

_____

2. Please describe the extent of the blindness

   a) What is the visual acuity of both eyes at present?

   Left: _____ Right: _____

b) What were the forms of treatment rendered?

_____

_____

_____

c) Will further surgery improve his / her sight? ☐ Yes ☐ No
If yes, what kind of surgery will be necessary.

_____

_____

_____

Please provide a copy of each related report including (but not limited to) ophthalmologist's reports, CT scans etc.

Section 8: Cancer

Definition: Cancer means the presence of uncontrolled growth and spread of malignant cells and invasion of tissue. Incontrovertible evidence of such invasion of tissue or definite histology of a malignant growth must be produced. It includes leukemia, Hodgkin's Disease and invasive melanoma which exceeds a depth of 0.75 millimetre. For the avoidance of doubt, the following shall not fall within the definition of 'Cancer' and are not covered under this Policy:

i. localised/non-invasive carcinoma in situ;
ii. localised/non-invasive tumours showing only early malignant changes;
iii. tumours in the presence of Human Immunodeficiency Virus;
iv. Karposi's Sarcoma and AIDS related cancers; and
v. any skin cancer other than malignant melanoma exceeding 0.75 mm in depth.

1. Please describe the extent of the disease.
   a) How was the diagnosis confirmed?

_____

_____

_____

b) What is the histological diagnosis of the disease?

_____

_____

_____

c) What is the staging of the Tumour? _____

d) Was the disease completely localised? ☐ Yes ☐ No

e) Was there spread of malignant cells to lymph nodes or distant parts of the body? ☐ Yes ☐ No
If yes, please describe degree of regional nodal involvement, and / or spread to distant parts of the body.

_____

_____

_____

_____

2. What is the nature of treatment?
   ☐ Surgical ☐ Radiotherapy ☐ Chemotherapy ☐ Palliative

Please provide details of procedure(s).

_____

_____

_____

3. Investigations: Was a biopsy of the tumour performed? ☐Yes ☐No

Please provide a copy of each related report and laboratory evidence including (but not limited to) biopsy reports, cytology reports, surgical reports, X-rays, CT scans, other imaging studies etc.

Section 9: Coma

Definition: Coma means a state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems for a period of at least ninety-six (96) hours, and resulting in a neurological deficit which in the opinion of Chubb's Chief Medical Officer is of the permanent nature. Coma resulting directly from alcohol or drug abuse is excluded.

1. Please describe the extent of the coma.

   a) Is there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system or at least 96 hours? ☐Yes ☐No

2. What was the cause of the coma?

   _____

   _____

   _____

Please provide a copy of each related report and laboratory evidence including (but not limited to) surgical reports, X-rays, CT scans, other imaging studies etc.

Section 10: Coronary Artery Bypass Surgery

Definition: Coronary Artery Bypass Surgery means open heart surgery undergone to correct narrowing or blockage of two or more coronary arteries by the use of saphenous vein grafts or internal mammary grafting. Angiographic evidence of the underlying disease must be provided. For the avoidance of doubt, non-surgical procedures such as balloon angioplasty or laser techniques shall not fall within the definition of 'Coronary Artery Bypass Surgery' and are not covered under this Policy.

1. Please describe the extent of the disease.
   a) Which arteries are involved and what is the degree of narrowing (%) in respect of each involved artery?

   _____

   _____

   _____

   b) Was coronary arteriography performed? ☐Yes ☐No

   What was the result of coronary angiography?

   _____

   _____

2. What is the nature of treatment?
   a) Was open heart surgery performed? ☐Yes ☐No
   If yes, state the number and sites of grafts inserted.

   _____

   _____

   _____

   b) What other forms of treatment were rendered?

   _____

   _____

   _____

Please provide a copy of each related report and laboratory evidence including (but not limited to) Thallium scans, X-rays, CT scans, surgical report, any other imaging studies, angiograms etc.

Section 11: Fulminant Viral Hepatitis

Definition: Fulminant Viral Hepatitis means a submassive to massive necrosis of the liver caused by the hepatitis virus, leading precipitously to liver failure. All following must be diagnosed:
i. a rapidly decreasing liver size;
ii. necrosis involving entire lobules, leaving only a collagen reticular framework;
iii. rapidly degenerating liver function tests; and
iv. deepening jaundice.
Liver failure due to other causes e.g. alcohol induced or drugs abused are excluded.

1. Please describe the extent of the illness.
   a) What is the diagnosis and etiological agent?

   _____

   _____

   _____

   b) Is there a rapidly decreasing liver size? ☐ Yes ☐ No

   c) Is there a submassive to massive necrosis of the liver? ☐ Yes ☐ No

   d) Is there a rapidly determination of liver function? ☐ Yes ☐ No

   e) Was there deepening jaundice? ☐ Yes ☐ No

2. What is the current condition of the Claimant?

   _____

   _____

   _____

Please provide a copy of each related report and laboratory evidence including (but not limited to) liver function tests, coagulation profiles, ultrasounds, MRI and other imaging studies etc.

Section 12: Heart Valve Replacement

Definition: Heart Valve Replacement means the actual undergoing of the replacement of one or more heart valves with artificial valves due to stenosis or incompetence. For the avoidance of doubt, heart valve repair and valvotomy shall not fall within the definition of 'Heart Valve Replacement' and are not covered under this Policy.

1. Please describe the extent of the illness.
   a) What was the cause of the heart valve defect?

   _____

   _____

   _____

2. Was open heart surgery performed?
   If yes, state the surgical procedure used to correct the valvular problem.

   _____

   _____

   _____

Please provide a copy of each related report and laboratory evidence including (but not limited to) surgical reports, X-rays, CT scans, angiograms and any other imaging studies etc.

Section 13: Kidney Failure

Definition: Kidney Failure means end stage renal disease which presents chronic and irreversible loss of function of both kidneys as a result of which the Claimant is required to undergo regular renal dialysis or kidney transplantation.

1. Please describe the extent of the kidney failure.
   a) Has the Insured's renal disease reach end stage? ☐ Yes ☐ No

b) Are both kidneys involved? ☐ Yes ☐ No

c) Is the Insured undergoing regular peritoneal dialysis or haemodialysis? ☐ Yes ☐ No
If yes, please indicate start date: DD / MM / YYYY

d) Has renal transplantation been advised or performed? ☐ Yes ☐ No

Please provide each copy of related report and laboratory evidence including (but not limited to) blood tests, X-rays, cystoscopy reports, pyelograms, ultrasounds, biopsy reports, surgical procedures and etc.

Section 14: Liver Failure

Definition: Liver Failure means chronic end stage liver failure which is permanent and irreversible and characterised by permanent jaundice, oesophageal varices, ascites and hepatic encephalopathy. For the avoidance of doubt, liver disease secondary to drug or alcohol abuse shall not fall within the definition of 'Liver Failure' and is not covered under this Policy.

1. Please describe the extent of the disease.

_____

_____

_____

2. Has the Claimant's liver failure reach end stage? ☐ Yes ☐ No
If yes,

a) Is there permanent jaundice? ☐ Yes ☐ No

b) Is there ascites? ☐ Yes ☐ No

c) Is there hepatic encephalpoathy? ☐ Yes ☐ No

d) Are there oesophageal varices? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) blood tests, X-rays, cystoscopy reports, pyelograms, ultrasound, biopsy reports, surgical procedures etc.

3. What was the cause of the chronic liver disease?

_____

_____

_____

4. What is the current condition of the Claimant?

_____

_____

_____

Please provide a copy of each related report and laboratory evidence including (but not limited to) liver function tests, ultrasound, MRI, other imaging studies etc.

Section 15: Loss Of Hearing

Definition: Loss of Hearing means total, bilateral and irreversible loss of hearing in both ears for all sounds as a result of acute sickness or accident. Medical evidence must be supplied by a licensed. (Ear, Nose and Throat) specialist to confirm the loss of hearing and must include audiometric and sound-threshold test.

1. Please describe the extent of the loss of hearing.

_____

_____

_____

a) Was the diagnosis confirmed by an audiometric and sound-threshold test? ☐ Yes ☐ No

b) Is the loss of hearing considered total and irreversible? ☐ Yes ☐ No

2. What was the cause of the loss of hearing?

_____

_____

_____

Please provide a copy of each related report and laboratory evidence including (but not limited to) audiometric, sound-threshold reports, X-rays, surgical reports etc.

Section 16: Loss Of Limbs

Definition: Loss of Limbs means loss by complete physical severance from the body of two (2) or more limbs where severance is above the wrist or ankle joint.

1. What was the cause?

_____

_____

_____

2. Which limbs were involved?

_____

_____

_____

3. At which part of the limb did the severance take place?

_____

_____

_____

4. Is this loss of limbs permanent?

_____

_____

_____

Please provide a copy of each related report and laboratory evidence including (but not limited to) surgical reports, X-rays etc.

Section 17: Loss Of Speech

Definition: Loss of Speech means total and irrecoverable loss of the ability to speak due to damage to vocal cords which must be established for a period of twelve (12) consecutive months. Medical evidence is to be supplied by a licensed (Ear, Nose and Throat) specialist to confirm permanent loss of speech and damage to vocal cords. For avoidance of doubt, loss of speech directly or indirectly due to psychiatric related causes shall not fall within the definition of 'Loss of Speech' and is not covered under this Policy.

1. Please describe the extent of the loss of speech.

_____

_____

_____

a) Duration of the loss of speech? _____

b) Is the loss of speech considered total and irrecoverable? ☐ Yes ☐ No

2. Was the loss of speech due to vocal cord damage? ☐ Yes ☐ No

Please provide each copy of related reports (Ear, Nose and Throat) and laboratory evidence including X-rays, surgical reports etc.

Section 18: Major Burns

Definition: Major Burns means burns which results in full thickness skin destruction of at least twenty percent (20%) of the total skin area of the body of the Claimant.

1. Please describe the extent of the major burns.

   _____

   _____

   _____

   a) Are the burns considered Third Degree Burns? If so, describe the extent (in percentages) of the burns covering the body surface.

   _____

   _____

   _____

2. What was the cause of the major burns?

   _____

   _____

   _____

Please provide a copy of each related report including (but not limited to) surgical reports etc.

Section 19: Major Organ Transplantation

Definition: Major Organ Transplantation means the actual undergoing of a transplant of the heart, lung, liver, pancreas or bone marrow as a recipient. For the avoidance of doubt, transplantation of isolated pancreatic islets shall not fall within the definition of 'Major Organ Transplantation' and is not covered under this Policy.

1. What is the diagnosis before the transplant?

   _____

   _____

   _____

   _____

   _____

2. Please describe the transplant operation. Which part of the organ is involved?

   _____

   _____

   _____

Please provide a copy of each related report and laboratory evidence including (but not limited to) surgical report, X-rays, CT Scans, ultrasound or other imaging studies, ECG, surgical reports etc.

Section 20: Motor Neuron Disease

Definition: Motor Neuron Disease means unequivocal diagnosis of Motor Neuron Disease by a consulting neurologist supported by obvious and definitive evidence of appropriate and relevant neurological signs with permanent neurological deficits.

1. Please describe the extent of the disease.

_____

_____

_____

_____

_____

a) Are there definitive evidence of permanent neurological deficits resulting from the disease? ☐ Yes ☐ No
If yes, please elaborate.

_____

_____

_____

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedures, CT scan, other imaging procedures etc.

Section 21: Muscular Dystrophy

Definition: Muscular Dystrophy means a hereditary muscular dystrophy confirmed by a consulting neurologist resulting in the inability of the Claimant to perform without assistance in respect of three or more of the following:

i. bathing
ii. dressing
iii. using the lavatory
iv. eating
v. movement in or out of bed or chair

1. Is the Claimant able to perform the following activities independently without any assistance from any other sources:
   a) Ability to wash and bathe ☐ Yes ☐ No
   b) Ability to dress / undress ☐ Yes ☐ No
   c) Ability to attend to toilet needs ☐ Yes ☐ No
   d) Ability to eat ☐ Yes ☐ No

2. Is there evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex? If yes, please describe findings.

_____

_____

_____

_____

3. Which are the muscles involved?

_____

_____

_____

4. Was the diagnosis confirmed
   a) by electromyogram? ☐ Yes ☐ No
   b) by muscle biopsy? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) all neurological reports, electromyogram studies, muscle biopsies etc.

Section 22: Myocardial Infarction

Definition: Myocardial Infarction means the death of a portion of the heart muscle as a result of inadequate blood supply to the areas. The diagnosis must be based on all of the following:

i. a history of typical chest pain;
ii. new electrocardiographic changes; and
iii. elevation of cardiac enzyme levels.

1. Was the claimant admitted to the Coronary Care Unit / Intensive Care Unit (CCU / ICU)? ☐ Yes ☐ No
   If yes, please state date of admission and duration of stay in CCU / ICU.

   _____

   _____

   _____

2. Was any thrombolytic therapy given? ☐ Yes ☐ No
3. Please describe the heart attack.

   _____

   _____

   _____

   a) When did the attack happen? DD / MM / YYYY

   b) Was there a recurrent history of typical chest pain? ☐ Yes ☐ No

   c) Was there a serial elevation of cardiac enzymes documented? ☐ Yes ☐ No

   d) Were there any changes in the ECG typical of an acute myocardial infarction? ☐ Yes ☐ No

   e) For how long did these acute symptoms exist? _____

   f) Has the Claimant return to normal activities? ☐ Yes ☐ No

   If yes, please advise the date DD / MM / YYYY

   g) What are the Claimant's present limitations, both physical and mental?

   _____

4. Was there death of a portion of the heart muscle? ☐ Yes ☐ No

Please provide a copy of each related report including (but not limited to) resting ECGs, exercise stress tests, enzymes assays, isotope studies, imaging (echocardiograms), coronary angiography etc.

Section 23: Paralysis

Definition: Paralysis means complete and permanent loss of use of two (2) or more limbs through neurological damage for the remainder of the Claimant's life.

1. Please describe the extent of the paralysis.

   _____

   _____

   _____

   a) Which areas were involved?

   _____

   _____

   _____

b) Is the loss of use of the involved limbs considered complete and permanent? ☐ Yes ☐ No
If yes, please provide basis for diagnosis.

_____

_____

_____

2. What was the cause of the paralysis?

_____

_____

_____

Please provide a copy of each related report and laboratory evidence including (but not limited to) neurological reports, X-rays, CT scans, MRI, other imaging studies, surgical reports etc.

Section 24: Parkinson's Disease

Definition: Parkinson's Disease means unequivocal diagnosis of Parkinson's Disease by a consultant neurologist where all the following conditions of the disease are fulfilled:

i. it cannot be controlled with medication;
ii. it is idiopathic in nature (all other forms of Parkinsonism are excluded);
iii. it shows signs of progressive impairment; and
iv. the inability of the Claimant to perform without assistance in respect of three or more of the following: bathing, dressing, using the lavatory, eating and movement in or out of bed or a chair.

1. Please describe the extent of the disease.

_____

_____

_____

_____

_____

_____

_____

_____

_____

a) What is the cause of the disease?

_____

_____

_____

_____

_____

2. Is the Claimant able to perform the following activities independently without any assistance from any other sources:

a) Ability to wash and bathe ☐ Yes ☐ No

b) Ability to dress/undress ☐ Yes ☐ No

c) Ability to attend to toilet needs ☐ Yes ☐ No

d) Ability to eat ☐ Yes ☐ No

e) Ability to move in or out of a bed or a chair ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedure, CT scans, other imaging procedures etc.

Section 25: Poliomyelitis

Definition : Poliomyelitis means unequivocal diagnosis by a consultant neurologist of infection by the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. Cases other than the foregoing shall not be regarded as poliomyelitis. For the avoidance of doubt, poliomyelitis not involving paralysis and other cases of paralysis shall not fall within the definition of 'Poliomyelitis' and are not covered under this Policy.

1. How was the diagnosis made and by whom?

_____

_____

_____

_____

2. Is there impaired motor function or respiratory weakness? ☐ Yes ☐ No
3. Are there any other causes of paralysis or weakness? ☐ Yes ☐ No
   If yes, please elaborate.

_____

_____

_____

_____

Please provide a copy of each related report and laboratory including (but not limited to) X-rays, CT scans, MRI and investigation results etc.

Section 26: Primary Pulmonary Arterial Hypertension

Definition : Primary Pulmonary Arterial Hypertension means primary pulmonary arterial hypertension as established by clinical and laboratory investigations including cardiac catheterisation. All of the following diagnostic criteria must be met:

i. dyspnea and fatigue
ii. increase left atrial pressure by at least 20 units;
iii. pulmonary resistance of at least 3 units above normal;
iv. pulmonary artery pressures of at least 40 mm Hg;
v. pulmonary wedge pressure of at least 8 mm Hg; and
vi. right ventricular end-diastolic pressure of at least 8 mm Hg; and
vii. right ventricular hypertrophy, dilation and signs of right heart failure and decompensation.

1. What was the extent of the primary pulmonary arterial hypertension?

_____

_____

_____

a) Was there dyspnea and fatigue? ☐ Yes ☐ No

b) Was there increase left atrial pressure of at least 20 units or more? ☐ Yes ☐ No

c) Was there pulmonary resistance of at least 3 units above normal? ☐ Yes ☐ No

d) Was there pulmonary artery pressure of at least 40mm Hg? ☐ Yes ☐ No

e) Was there pulmonary wedge pressure of at least 8mm Hg? ☐ Yes ☐ No

f) Was there right ventricular end-diastolic pressure of at least 8mm Hg? ☐ Yes ☐ No

g) Was there right ventricular hypertrophy, dilation and signs of right heart failure and decompensation? ☐ Yes ☐ No

2. In your medical opinion, what was the cause of the primary pulmonary arterial hypertension?

_____

_____

_____

Please provide a copy of each related reports and laboratory evidence including (but not limited to) ECGs, X-rays, ultrasound, cardiac catherisation, pulmonary function studies etc.

Section 27: Progressive Bulbar Palsy

Definition: Progressive Bulbar Palsy means degenerative wasting of the muscles including the bulbar muscles as diagnosed by a consultant neurologist and agreed to by Chubb's Chief Medical Officer.

1. How was the diagnosis made and by whom?

_____

_____

_____

2. Is there degenerative wasting of muscles including bulbar muscles? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) investigation results, X-rays, CT scans, MRI etc.

Section 28: Progressive Muscular Atrophy

Definition: Progressive Muscular Atrophy means involving the wasting of muscles and increased spasticity as diagnosed by a consultant neurologist and agreed by Chubb's Chief Medical Officer.

1. How was the diagnosis made and by whom?

_____

_____

_____

2. Is there wasting of muscles? ☐ Yes ☐ No
3. Is there increased spasticity of muscles? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) investigation results, X-rays, CT scans, MRI etc.

Section 29: Severe Brain Damage

Definition: Severe Brain Damage means impairment or loss of intellectual capacity as a result of brain damage sustained in an accident, following which permanent and constant supervision or assistance is required to maintain existence of the Claimant.

1. Date of Accident DD / MM / YYYY
2. What was the injury to the brain?

_____

_____

_____

3. Was the brain damage directly caused by the accident? ☐ Yes ☐ No
   If no, please elaborate.

_____

_____

_____

4. Is there permanent loss of intellectual capacity such that he requires constant supervision or assistance? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) investigation results, X-rays, CT scans, MRI etc.

Section 30: Stroke

Definition: Stroke means any cerebrovascular incident producing neurological sequelae lasting for more than twenty four (24) hours and including infarction of brain tissue, haemorrhage of an intracranial vessel, or embolisation from an extracranial source. Evidence of permanent neurological deficit must be produced. For the avoidance of doubt, transient ischemic attacks shall not fall within the definition of 'Stroke' and is not covered under this Policy.

1. What is the pathological diagnosis?

   _____

   _____

   _____

2. Please describe the initial episode.

   a) Date of episode DD / MM / YYYY

   b) Nature of episode

   _____

   _____

   _____

   c) Duration of the acute symptoms _____

   d) Date of return to normal activities DD / MM / YYYY

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

   _____

   _____

   _____

   a) Are these sequelae permanent? ☐ Yes ☐ No

   b) How long have these sequelae been present since the initial episode? Please give the number of days / months. _____

   c) What are the Claimant's present limitations both physical and mental?

   _____

   _____

   _____

4. Has there been an infarction of brain tissue, cerebral haemorrhage, or embolisation from an extracranial source? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedures, CT scans, other imaging procedures, etc.

Section 31: Surgery To Aorta

Definition: Surgery to Aorta means the actual undergoing of an open heart surgery for disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purposes of this definition, aorta shall mean the thoracic and abdominal aorta, but not its branches. A surgery performed to cure traumatic injury to the aorta shall not be regarded as 'Surgery to Aorta' and is not covered under this Policy.

1. Please describe the extent of the disease.

   _____

   _____

   _____

2. Was excision and surgical replacement of the diseased aorta with a graft performed through open surgery? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) surgical reports, X-rays, CT scans, angiograms and any other imaging studies etc.

Section 32: Terminal Illness

Definition: Terminal Illness means the Claimant must be suffering from a disease which in the opinion of a licensed medical consultant and supported by Chubb's Chief Medical Officer, is likely to lead to death within six (6) months from the date of notification of a claim under this Policy.

1. Please describe the terminal illness.

_____

_____

_____

_____

_____

a) What is the nature of treatment?

_____

_____

_____

_____

_____

b) In your opinion is the condition highly likely to lead to death within 6 months? ☐ Yes ☐ No

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedures, CT scans, X-rays, other imaging procedures etc.

Section 33: Total And Permanent Disability

Definition: Total and Permanent Disability means the inability of the Claimant to engage in any occupation or employment for remuneration or profit as a result of bodily injury or sickness and the inability of the Insured Person to perform without assistance in respect of three or more of the following : bathing, dressing, using the lavatory, eating and movement in or out of bed or a chair. The 'Total and Permanent Disability' must have continued without interruption for at least six (6) consecutive months, or for such longer period as Chubb may reasonably require to establish that such disability is and will be total, continuous and permanent for the remainder of the Claimant's life.

1. What is the cause of the disability?

_____

_____

_____

2. Is the Claimant able to perform the following activities independently without any assistance from any other sources:
   a) Ability to wash and bathe ☐ Yes ☐ No
   b) Ability to dress/undress ☐ Yes ☐ No
   c) Ability to attend to toilet needs ☐ Yes ☐ No
   d) Ability to eat ☐ Yes ☐ No
   e) Ability to move in or out of a bed or a chair ☐ Yes ☐ No

3. Is this disability total, continuous and permanent for the remainder of the Claimant's life? ☐ Yes ☐ No
   If yes, please elaborate.

_____

_____

_____

Please provide a copy of each related report and laboratory evidence including (but not limited to) radiological procedure, CT scans, other imaging procedures etc.

Section 34: Details of Claimant's Illness

1. Please provide Name, Address and Contact No. of the Doctor(s) who referred the Claimant to you.

   _____

   _____

2. Has the Claimant been suffering from / been treated for any other illness(es)/complaints other than this Critical Illness?
   ☐ Yes ☐ No

3. Is there any further information which is in your opinion, will assist us in assessing this claim? If there is, please furnish such information.
   ☐ Yes ☐ No

4. In your opinion, does the patient's medical condition fulfill our policy definition in respect of the critical illness as diagnosed by you in this episode?
   ☐ Yes ☐ No

Section 35: Details of Attending Physician / Specialist

Name of Attending Physician

_____

Qualifications

_____

Address of Physician's Hospital/Clinic

_____

_____ Postal Code_____

_____ _____

Signature of Physician
(with Official Stamp of Hospital / Clinic)

Date

Chubb. Insured.℠

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