CAPITAL ALLIANCE LIFE LIMITED
Reg. No 1969/008/87/06
Libridge Building, 25 Ameshoff Street,
Braamfontein, 2001
P O Box 31750, Braamfontein, 2017
Tel: +27 11 408 3911 Fax: +27 11 694 5458

CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

Claim for Critical Condition Benefit
Personal Statement

CAL Clms HBR personal statement

Tick where applicable | To be completed by claimant | Please use a black pen and block letters

I, _____ ,(full names of claimant) hereby declare that I am the person assured under the Scheme mentioned below. All the particulars given, whether in my handwriting or not, are to the best of my knowledge, true and complete. I accept full responsibility for any inaccuracies or omissions contained in this personal statement and I understand that the Insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the Insurer.

I accept that I am hereby curtailing my right to privacy, but to facilitate the assessment of the risks, and the consideration of any claim for benefit, under a policy related to this or any other proposal for insurance made by me, or in respect of me as life assured, I irrevocably authorise Capital Alliance:

(a) to obtain from any person, whom I hereby so authorise and request to give any information which Capital Alliance deems necessary, and

(b) to share with other Insurers that information and any information contained in this proposal or in any related policy or other document, either directly or through a data base operated by or for insurers as a group, at any time (even after my death) and in such detailed abbreviated code form as may from time to time be decided by Capital Alliance or by operators of such data base.

It is imperative that this form is completed as comprehensively as possible and returned to Capital Alliance, P O Box 31750, Braamfontein, 2017 or faxed to (011) 694 5458 or emailed to ebuwmail@grouprisk.co.za

1. Claimant's personal details

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

Occupation _____

Address _____

Under what condition are you claiming payment of the benefit?

Heart Attack	☐	Cancer	☐	Stroke	☐	Kidney failure	☐	Blindness	☐
Alzheimers disease	☐	Multiple sclerosis	☐	Major organ transplant	☐				
Coronary artery disease requiring surgery	☐			Paraplegia / quadriplegia / diplegia	☐	Other	☐		

2. Medical history

Do you have, or have you ever had, any of the following:
(If "Yes", please state full details of each instance in the schedule relating to question 2.13)

2.1	Disorder of the heart, for example rheumatic fever, heart murmur, shortness of breath, palpitations, Chest pain, angina pectoris or coronary thrombosis?	☐ Yes ☐ No
2.2	High blood pressure, disease of the blood vessels or circulatory disorder, for example cramps in the calves Calves with the exercise or walking, stroke, etc?	☐ Yes ☐ No
2.3	Respiratory or lung trouble, for example asthma, bronchitis, persistent cough, tuberculosis?	☐ Yes ☐ No
2.4	Disorder of the digestive system, gall bladder, pancreas or liver, for example gastric or duodenal ulcer, recurrent indigestion, rectal bleeding?	☐ Yes ☐ No
2.5	Disease or disorder of the kidneys, bladder or reproductive organs, for example protein in the urine, kidney Stones, prostatitis, cystitis?	☐ Yes ☐ No
2.6	Nervous complaint, for example epilepsy, blackouts, paralysis, anxiety or transient ischaemic attrack?	☐ Yes ☐ No
2.7	Eye disorder, for example defective vision?	☐ Yes ☐ No

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2.8 Diabetes or sugar in urine? ☐ Yes ☐ No

2.9 Disturbance of speech, vision or weakness of a limb or limbs? ☐ Yes ☐ No

2.10 Disturbance of memory or judgement or loss of personality or emotional control? ☐ Yes ☐ No

2.11 Cancer, growth or tumour of any kind? ☐ Yes ☐ No

2.12 Any other illness, disorder, operation, disability or accident? ☐ Yes ☐ No

2.13

Question number	Dates		Nature, duration and severity of complaint or symptoms	Hospital or doctor	Address/es and telephone numbers
	From	To			
	/ /	/ /			
	/ /	/ /			
	/ /	/ /			
	/ /	/ /			
	/ /	/ /			
	/ /	/ /			
	/ /	/ /			
	/ /	/ /			

2.14 On what did you first consult a medical practitioner in connection with your condition? / /

2.15 Please print the name, address and telephone number of your usual/attending doctor?

2.16 Are you insured for similar benefits with any other company? ☐ Yes ☐ No

If "Yes", state the name of the insurer, the amount of benefit insured and whether or not you have submitted a claim in connection with such insured benefits.

Please note

1) The request for completion of this form in no way constitutes an admission of liability by Capital Alliance

2) The cost of completing any medical report/s must be borne by the claimant.

Thank you for your assistance

Date / /

Signature of claimant

Name and address of witness

Signature of witness

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CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

Claim for Critical Condition Benefit
Confidential Neuropsychologist's Medical Report

CAL Clms HBR Alzheimer's disease

Tick where applicable | To be completed by the attending neuropsychologist | Please use a black pen and block letters

Alzheimer's Disease

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

The deterioration or loss of intellectual capacity or abnormal behaviour arising from Alzheimer's disease or irreversible organic disorder (excluding neurosis and any psychiatric illness) resulting in significant reduction in mental and social functioning and requiring the eventual supervision of the Life Insured. The diagnosis must be clinically confirmed by an appropriate consultant and confirmed by Capital Alliance Group Risk's medical consultants.

1. When were you first consulted for this condition?

_____

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests e.g. CT scan, MRI scan, etc. and reports conducted to confirm the diagnosis are enclosed).

_____

_____

_____

_____

3. Final diagnosis:

_____

4. On what date was the diagnosis made? ___/___/___

_____

5. Are you aware of any factors in the claimant's family history which would have increased the risk of Alzheimer's disease?

_____

_____

_____

_____

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6. What tests have been carried out to rule out other possible conditions (i.e. hypothyroidism, vitamin B12 deficiency, etc.)?

NB. Have you enclosed copies of all tests and reports done? ☐ Yes ☐ No

Doctor's name and address (please print).

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

I declare and warrant that all information provided by me in this confidential medical report is complete and true. I accept full responsibility for any inaccuracies or omissions contained in this confidential medical report and I understand that the Insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the Insurer.

Doctor's signature

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CAPITAL ALLIANCE
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Claim for Critical Condition Benefit
Confidential Ophthalmologist's Medical Report

CAL Clms HBR Blindness

Tick where applicable | To be completed by the attending ophthalmologist | Please use a black pen and block letters

Blindness

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

The total, permanent and irreversible loss of sight in both eyes, whether aided or not. The diagnosis must be confirmed by an ophthalmologist.

1. When were you first consulted for this condition?

_____

2. Is there an underlying disease causing the blindness?

_____

3. On what date was the diagnosis made? ___/___/___

4. Has there been complete and irreversible loss of sight in both eyes? ☐ Yes ☐ No

   If "Yes", please elaborate _____

   _____

5. On what date did the claimant first become aware of the blindness? ___/___/___

6. Is there any treatment e.g. laser, etc. That could assist the claimant? ☐ Yes ☐ No

   If "Yes", please elaborate _____

   _____

7. Please provide the full name/s and address/es of any hospital/s to which the claimant has been referred, together with details of the attending doctors.

Name of hospital	Address of hospital	Telephone number of hospital	Doctor's name	Doctor's telephone number

Please note that in the event of any modification or variation of this standard form Capital Alliance will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

NB: Have you enclosed copies of - Visual acuity readings (if applicable) ☐ Yes ☐ No

- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print).

_____

_____

_____

Telephone number ( ) _____ Fax number ( ) _____

Cellular number _____ Practice number _____

E-mail address _____ Date / /

Qualifications _____

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Doctor's signature _____

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CAPITAL ALLIANCE
Group Risk
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Claim for Critical Condition Benefit
Confidential Oncologist's Report

CAL Clms HBR Cancer

Tick where applicable | To be completed by the attending oncologist | Please use a black pen and block letters

Cancer

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

The manifestation of uncontrolled growth and spread of malignant cells with the invasion and destruction of normal tissue. Included are Leukaemia and Hodgkin' disease. The diagnosis must be confirmed by a histological report from an accredited pathology laboratory and oncologist.

All skin cancers, with the exception of malignant melanomas are excluded.

1. When were you first consulted for this condition?

_____

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests are enclosed).

_____

_____

_____

_____

3. Final diagnosis

_____

4. On what date was the diagnosis made? / /

5. Has the claimant suffered from any other malignant conditions in the past although unrelated to the present cancer: ☐ Yes ☐ No

   If "Yes", please comment fully,

_____

6. Are you aware of any factors in the claimant's family history which would have increased the risk of cancer?

_____

_____

_____

_____

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7. Has the claimant been exposed to carcinogens or cancer producing chemicals in his/her social or occupational environment (including cigarette smoking)? ☐ Yes ☐ No

If "Yes", please comment fully.

8. What was the site or organ involved in the precise histology of the tumour?

9. If no biopsy evidence was obtained or histological confirmation of the diagnosis made, please describe the basis on which the diagnosis of cancer was made?

10. What stage has the disease reached? Please explain this using the appropriate staging classification.

11. Was the cancer completely localised to the tissue or organ of origin? ☐ Yes ☐ No

12. Were regional lymph nodes involved? ☐ Yes ☐ No

13. Was there any metastases? ☐ Yes ☐ No

If so, please state where

14. If the diagnosis is leukaemia, please provide details of the actual type?

NB: Have you enclosed copies of

- Histology report/s ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print).

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

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Doctor's signature

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CAPITAL ALLIANCE
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Claim for Critical Condition Benefit
Confidential Cardiothoracic Surgeon's Reports

CAL Clms HBR coronary artery disease requiring surgery

Tick where applicable | To be completed by the attending cardiothoracic surgeon | Please use a black pen and block letters

Coronary Artery Disease requiring surgery

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

The actual undergoing of coronary bypass surgery by way of thoractomy to correct or treat coronary artery disease not including angioplasty, other intra-arterial, keyhole or laser procedures.

The following are therefore excluded from this benefit:

- Percutaneous transluminal coronary angioplasty (PTCA)
- Laser therapy
- Stenting

1. When were you first consulted for this condition?

_____

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests. i.e. coronary angiograms, etc. and reports conducted to confirm the diagnosis are enclosed).

_____

_____

_____

_____

3. Final diagnosis:

_____

4. On what date was the diagnosis made? ___/___/___

5. Are you aware of any factors in the claimant's family history which would have increased the risk of coronary artery disease?

_____

_____

_____

_____

Please note that in the event of any modification or variation of this standard form Capital Alliance will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

6. Are you aware of whether the claimant has previously suffered from any associated illnesses such as hypertension, angina, peripheral vascular disease, abdominal aortic aneurysm, transient ischaemic attack, stroke, etc. If " Yes", please supply:

Date	Reason for consultation	Diagnosis	Treatment	Result/prognosis
/ /				
/ /				
/ /				
/ /				

7. If the claimant had history of angina, please explain whether this **became progressively worse** or in fact **uncontrolled with medication**.

8. What type of surgery was performed and when was this procedure performed (e.g. angioplasty, coronary artery bypass grafting, etc.)?

Please ensure copies of all surgery notes are enclosed

9. Was surgery previously recommended? ☐ Yes ☐ No

If " Yes", please provide full details regarding:

a) Type of surgery recommended

b) Date surgery was recommended / /

c) Confirmation whether this was in fact performed (if applicable) and when

d) Name of Attending Physician

NB. Have you enclosed copies of:
- Coronary angiogram ☐ Yes ☐ No
- Surgery Report ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print)

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

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Doctor's signature _____

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CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

Claim for Critical Condition Benefit
Confidential Cardiologist's Report

CAL Clms HBR Heart Attack

Tick where applicable | To be completed by the attending cardiologist | Please use a black pen and block letters

Heart Attack

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

The death of a portion of the heart muscle, as a result of inadequate blood supply to the relevant area. The diagnosis will be supported, if a cardiologist confirms the following:

- A history of typical chest pain
- New ECG changes compatible with an acute myocardial infarction
- The elevation of specific cardiac enzymes above standard laboratory levels or
- An elevation in the levels of the biomarker Troponin

1. When were you first consulted for this condition?

_____

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests e.g. cardiac enzymes, R & E ECG, coronary angiograms etc, and reports conducted to confirm the diagnosis are enclosed).

_____

_____

_____

_____

3. Final diagnosis.

_____

4. On what date was the diagnosis made? ___/___/___

_____

5. Are you aware of any factors in the claimant's family history which would have increased the risk of coronary artery disease?

_____

_____

_____

_____

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6. Are you aware of whether the claimant has previously suffered from any associated illnesses such as hypertension, angina, peripheral vascular disease, abdominal aortic aneurysm, transient ischaemic attack, stroke, diabetes, elevated lipid levels, etc. ☐ Yes ☐ No
If "Yes", please supply:

Date	Reason for consultation	Diagnosis	Treatment	Result/ prognosis
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				

7. If the claimant had a history of angina, please explain whether this **became progressively worse** or in fact **uncontrolled with medication.**

NB. Have you enclosed copies of:

- Cardiac enzymes results ☐ Yes ☐ No
- R & E ECG ☐ Yes ☐ No
- Coronary angiogram report ☐ Yes ☐ No
- Echocardiogram report ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print).

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

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Doctor's signature

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CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

Claim for Critical Condition Benefit
Confidential Nephrologist's Report

CAL Clms HBR kidney failure

Tick where applicable | To be completed by the attending nephrologist | Please use a black pen and block letters

Kidney Failure

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

Bilateral end stage renal failure, which requires regular peritoneal dialysis or haemodialysis.

1. When were you first consulted for this condition?

_____

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests. i.e. renal function test, IVP, etc. and reports conducted to confirm the diagnosis, are enclosed).

_____

_____

_____

_____

3. Final diagnosis.

_____

4. On what date was the diagnosis made? ___/___/___

5. Is the claimant currently undergoing regular dialysis? ☐ Yes ☐ No

   If "Yes", please supply the following details:

   a) Type of dialysis _____

   b) Date treatment commented ___/___/___

   c) Frequency _____

6. Is the claimant currently considered for a kidney transplant, or has this already been done? Please supply full details:

   Currently considered for a kidney transplant ☐ Yes ☐ No

   Kidney transplant done? ☐ Yes ☐ No

   Date of the surgery (if applicable) ___/___/___

Please note that in the event of any modification or variation of this standard form Capital Alliance will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

7. Are you aware of any factors in the claimant's family history which would have increased the risk of chronic renal failure?

8. Are you aware of whether the claimant has previously suffered from any associated illnesses such as diabetes, hypertension, etc? If " Yes", please supply:

Date	Reason for consultation	Diagnosis	Treatment	Result/prognosis
/ /				
/ /				
/ /				
/ /				

NB. Have you enclosed copies of:

- Renal function test results ☐ Yes ☐ No
- IVP report ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print)

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

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Doctor's signature

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CAPITAL ALLIANCE
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Claim for Critical Condition Benefit
Confidential Surgeon's Report

CAL Clms HBR major organ transplant

Tick where applicable | To be completed by the attending surgeon | Please use a black pen and block letters

Major Organ Transplant

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth / /

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Definition

In terms of the policy conditions:

The recipient of any one of the following major organs, heart, lung/s, kidney/s, liver or pancreas (excluding the transplantation of the islets of Langerhans) or transplantation of bone marrow from a donor. The transplantation of all other organs, part of organs or any other tissue or cells is excluded.

1. When were you first consulted for this condition?

2. Describe in full how the diagnosis was established. (Please ensure that copies of all investigative tests e.g. R & E ECG, coronary angiograms, pulmonary and renal function tests, biopsy results, etc. and reports conducted to confirm the diagnosis are enclosed).

3. Final diagnosis:

4. On what date was the diagnosis made? / /

5. On what date was the need for a transplant confirmed? / /

6. Are you aware of any factors in the claimant's family history which would have increased the risk of the incident claimed for?

7. Are you aware of whether the claimant has previously suffered from any associated illnesses such as hypertension, angina, peripheral vascular disease, diabetes, elevated lipid levels, etc. If "Yes", please supply further clarification:

Date	Reason for consultation	Diagnosis	Treatment	Result/prognosis
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				

Please note that in the event of any modification or variation of this standard form Capital Alliance will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

8. If the claimant had a history of angina, please explain whether this **became progressively worse** or was in fact **uncontrolled with medication.**

NB. Have you enclosed copies of:

- All surgery notes ☐ Yes ☐ No
- All reports, tests, special investigations etc. in connection with the incident claimed for ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence. ☐ Yes ☐ No

Doctor's name and address (please print).

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

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Doctor's signature

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CAPITAL ALLIANCE
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Claim for Critical Condition Benefit
Confidential Neurologist's Report

CAL Clms HBR multiple sclerosis

Tick where applicable | To be completed by the attending neurologist | Please use a black pen and block letters

Multiple Sclerosis

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

The unequivocal diagnosis of multiple sclerosis confirmed with a reliable history and clinical findings made by a consultant neurologist (and confirmed by Capital Alliance's medical consultants) supported by CT or MRI scans where demyelination in the brain and spinal cord characterises the condition. More than one episode and progression must be shown and a single episode from which remission has occurred will not be considered.

1. When were you first consulted for this condition?

_____

2. What were the claimant's presenting symptoms?

_____

3. Describe in full how the diagnosis was established. (Please ensure that copies of all investigative tests i.e. CT scan, MRI, CSF test etc, and reports conducted, to confirm the diagnosis, are enclosed)

_____

_____

_____

_____

4. Final diagnosis.

_____

5. On what date was the diagnosis made? ___/___/___

6. Map the course of the symptoms and condition from the date of the first consultation to current.

_____

_____

_____

_____

_____

_____

Please note that in the event of any modification or variation of this standard form Capital Alliance will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

7. How many previous episodes has the claimant had?

NB. Have you enclosed copies of:

- MRI report ☐ Yes ☐ No
- CT scan report ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print)

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

I declare and warrant that all information provided by me in this confidential medical report is complete and true. I accept full responsibility for any inaccuracies or omissions contained in this confidential medical report and I understand that the Insurer may bring criminal or civil charges against me in the event that any such inaccuracies or omissions are discovered by the Insurer.

Doctor's signature

Please note

1) **The request for completion of this form in no way constitutes an admission of liability by Capital Alliance**
2) **The cost of completing any medical report/s must be borne by the claimant.**

Thank you for your assistance

CAPITAL ALLIANCE LIFE LIMITED
Reg. No 1969/008/87/06
Libridge Building, 25 Ameshoff Street,
Braamfontein, 2001
P O Box 31750, Braamfontein, 2017
Tel: +27 11 408 3911 Fax: +27 11 694 5458

CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

Claim for Critical Condition Benefit
Confidential Neurologist Report

CAL Clms HBR paraplegia/ quadriplegia/ diplegia

Tick where applicable | To be completed by the attending neurologist/neurosurgeon | Please use a black pen and block letters

Paraplegia / quadriplegia (tetraplegia) / diplegia

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

Capital Alliance Group Risk has received an application from the abovementioned to assess a potential benefit against the occurrence or diagnosis of the above medical condition. It is therefore imperative that this form is completed as comprehensively as possible and returned, **together with all the supporting clinical evidence**, to Capital Alliance, P O Box 31750, Braamfontein, 2017 or faxed to (011) 694 5458 or emailed to ebuwmail@grouprisk.co.za

Definition

In terms of the policy conditions:

- Paraplegia
  The total and permanent loss of use of both legs due to a disease or injury of the spinal cord as confirmed by a neurologist/ neurosurgeon
- Quadriplegia (Tetraplegia)
  The total and permanent loss of use of both arms and both legs, due to a disease or injury of the spinal cord as confirmed by a neurologist/ neurosurgeon
- Diplegia
  The total and permanent loss of use of both sides of the body due to a disease or injury of the spinal cord, where the legs are more affected than the arms as confirmed by a neurologist/ neurosurgeon.

1. When were you first consulted for this condition?

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests e.g. X-rays, CT scans, myelograms, etc. conducted to confirm the diagnosis are enclosed).

3. If trauma-related, please specify full details regarding the type of injury i.e. disc level, etc.

4. If illness-related, please supply detailed medical history leading to current medical condition,

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5. Final diagnosis.

6. On what date was the diagnosis made? / /

7. Prognosis.

NB. Have you enclosed copies of:

- X-ray reports ☐ Yes ☐ No
- CT scan reports ☐ Yes ☐ No
- Myelogram reports, etc. ☐ Yes ☐ No
- Any other clinical / diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print).

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

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CAPITAL ALLIANCE
Group Risk
A division of Liberty Corporate

Claim for Critical Condition Benefit
Confidential Neurologist's Report

CAL Clms HBR stroke

Tick where applicable | To be completed by the attending neurologist or neurosurgeon | Please use a black pen and block letters

Stroke

Scheme name _____ Scheme number _____

Claimant's name _____ Claimant number _____

Date of birth ___/___/___

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Definition

In terms of the policy conditions:

Any cerebrovascular incident producing neurological sequelae lasting more than 24 hours including infarction of brain tissue, haemorrhage or embolisation from an intra or extra cranial source. A neurologist or neurosurgeon must confirm evidence of a permanent neurological deficit after the event (prior to which no claims can be admitted).

Excluded are transient ischaemic attacks, migraines, vascular disease affecting the eye or optic nerve or cerebral injury resulting from trauma or systemic hypoxia.

1. When were you first consulted for this condition?

_____

2. Describe in full how the diagnosis was established? (Please ensure that copies of all investigative tests. i.e. CT scan, MRI scan, etc. and reports conducted to confirm the diagnosis are enclosed).

_____

_____

_____

_____

3. Final diagnosis.

_____

4. On what date was the diagnosis made? ___/___/___

_____

5. Are you aware of any factors in the claimant's family history which would have increased the risk of a stroke?

_____

_____

_____

_____

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6. Are you aware of whether the claimant has previously suffered from the condition or any associated illness such as hypertension, TIA, ischaemic heart disease or any other vascular disease? If "Yes", please supply:

Date	Reason for consultation	Diagnosis	Treatment	Result/prognosis
/ /				
/ /				
/ /				
/ /				

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

8. Are these sequelae permanent? ☐ Yes ☐ No

9. Was surgery recommended for cardiovascular disease? If "Yes", please provide full details.

NB. Have you enclosed copies of:

- MRI scan report ☐ Yes ☐ No
- CT scan report ☐ Yes ☐ No
- Any other clinical/ diagnostic evidence ☐ Yes ☐ No

Doctor's name and address (please print).

Telephone number ( ) Fax number ( )

Cellular number Practice number

E-mail address Date / /

Qualifications

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Doctor's signature

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Thank you for your assistance