YFLife
萬通保險

Supplement of Critical Illness & Total Disability Benefit Claim Form Part II-STROKE

The issue of this claim form is in no way an admission of liability. No fee, commission or charge of whatever nature is required to pay to the employees or agents of the company with respect to this claim. YF Life Insurance International Ltd. will not be responsible for any fee the completion of this report.

Policy No. :

Name of Patient :

HKID Card/Passport No. :

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1) We understand that the patient suffered from stroke, please advise:

   a) Nature of the attack

   b) Signs and Symptoms and their duration

   c) Date of return to normal activities

   d) Present condition

2) a) Did the cardiovascular incident (or accident) produce neurological sequelae? If so, please give details.

   b) If the abovementioned neurological sequelae existed, how long they lasted?

   c) Any other neurological deficit existed? Please advise the details and how long they last.

3) Did any permanent neurological deficit persist for six consecutive months? Please give details.

   Neurological deficit:

   Start date of the deficit:

   End date of the deficit:

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Name of Patient: ___________________ HKID Card No.: ________________________

4) Did the patient had any history of other major/illness that was related to his/her current suffering? Please elaborate.

5) Please state the period in which the patient was totally disabled i.e. incapable of engaging in any work or occupation whatsoever for remuneration or profit?

From (MM/DD/YY) To (MM/DD/YY)

6) What is the main reason of the patient's total disability?

7) Please give details the condition of the patient during last follow-up consultation.

Last follow-up date:

Condition:

8) How would you comment on the patient's past health history?

9) Had the patient suffered from other related illness such as chest pain, hypertension? Please advise the below information:

Date Diagnosis Attending Doctor Treatment

10) Any other information to supplement the above?

I hereby certify that I have personally attended the above named patient and that all the information supplied by me on this form is true and correct to the best of my knowledge and belief.

Name of practitioner	Qualification(s)	Date
Medical Practitioner's Signature (With Chop)	Specialty/Department/Unit (if from hospital)	Contact Number