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:

   e) 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? Please state period and 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) Was the neurological deficit caused by the following condition?

- ☐ Cerebral symptoms due to transient ischaemic attacks (TIA)
- ☐ Cerebral symptoms due to migraine
- ☐ Vascular disease affecting the eye or optic nerve or vestibular functions

5) Did the patient had any history of other illness that was related to his/her current suffering such as chest pain, hypertension? Please elaborate.

Date	Diagnosis	Attending Doctor	Treatment

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

Last follow-up date:

Condition:

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

8) 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