ZURICH

Group Major Illness

Medical Information Questionnaire – Treating Medical Specialist

Stroke

To be completed by the claimant's treating medical specialist.

This questionnaire is designed to obtain information in relation to a claimant who has been diagnosed as having suffered a stroke.

If there is a cost associated with the completion of the form, it is the responsibility of the claimant.

1 Claimant's details

a. Surname (Family Name)

b. Given name/s

c. Date of Birth / /

2 History

a. How long have you known the claimant? years months

b. Are you the claimant's usual treating specialist? Yes ◯ No ◯

c. Has the claimant been diagnosed with this condition, or any contributing symptoms previously? Yes ◯ No ◯

If 'Yes', when? / /

3 Details of the claimant's Major Illness

The following questions are designed to assist us in the assessment of the claimant's insurance claim for Major Illness Benefits. It is important that you provide detailed answers to assist us in our assessment.

a. Has the claimant's diagnosis of having suffered a cerebrovascular accident been based on:

i. CT scan; or

ii. MRI; or

iii. PET Scan.

Please state which and provide a copy of the supporting neuro-imaging and reports.

b. Has the claimant's cerebrovascular accident occurred as a result of an embolism interrupting blood and oxygen flow to the brain or bleeding? Please explain which and what area of the brain has been affected.

ZU20979 - V2 03/14 - SROE-008692-2014

3 Details of the claimant's Major Illness (continued)

c. How long did the symptoms of the cerebrovascular accident last? Did the neurological sequel last at least 24 hours and were the symptoms of the CVA reversible?

.....

.....

.....

d. Has the claimant's cerebrovascular accident been classified as a transient ischaemic attack? Yes ◯ No ◯

e. If the claimant has suffered intracranial bleeding, please explain whether this was caused by trauma.

.....

.....

.....

f. Please explain whether the claimant has suffered ischaemic neurological deficit which is reversible? Yes ◯ No ◯

.....

.....

.....

4 Declaration

I hereby declare that the above statements are true and correct.

Signature of Doctor / Specialist / Consultant	Date
✗	/ /

Name .....

Address .....

Qualifications .....

Telephone number Email .....

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). In completing the forms or questions herein you will be providing us with personal and, perhaps, sensitive information. The collection and management of this information is governed by the Privacy Act 1988. For a more detailed explanation of Zurich's Privacy Policy please visit our website at www.zurich.com.au or contact the Zurich Privacy Officer on 132 687 or email us at privacy.officer@zurich.com.au

Please send your completed form to:

Zurich Australia Limited
Group Risk Insurance
Locked Bag 994
North Sydney NSW 2059