



4. (a) What is the cause of the hearing loss, accident/illness?

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(b) Is this hearing loss permanent?

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(c) Is there any treatment that could improve the hearing?

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5. Please describe, including dates, any predisposing disorders or risk factors that your patient had for hearing loss.

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6. Please give the names and addresses of other physicians consulted or hospitals attended by your patient for this or any related disorder.

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7. State the periods in which the patient was confined to hospital, bed or home.

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8. Please provide details of any significant family history.

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9. When do you expect the patient would return to work?.

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10. Please provide any other information that would be helpful in the assessment of your patient's claim.

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Please provide copies of any specialist or hospital reports for our Consultant's review, dated within the last six (6) months.

Our contract requires that a covered illness be diagnosed by a physician who is not related to or in a business relationship with the insured. Are you related to or in a business relationship with this patient:    Yes                          No   

Signature: \_\_\_\_\_

Dated: \_\_\_\_\_

Name (in block capitals please): \_\_\_\_\_