CONFIDENTIAL MEDICAL CERTIFICATE (CRITICAL ILLNESS - CANCER)

Great Eastern TAKAFUL

Certificate No. | | | | | | | | | | | New NRIC No. | | | | | | | - | | | - | | | |

Certificate No. | | | | | | | | | | | Old NRIC/Birth Certificate/ Passport No. | | | | | | | | | | | | | | | | | | | | | |

Certificate No. | | | | | | | | | | |

Certificate No. | | | | | | | | | | | Name of Person Covered _____

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted in connection with **CANCER** and to enable us to assess the claim, kindly complete this confidential report. (For any medical report fee incurred in completing this form, it will be borne by claimant)

Please attach certified true copies of all the relevant laboratory evidences or tests available.

- ☐ Histopathology examination (HPE) / Biopsy report
- ☐ Bone marrow aspiration / trephine biopsy report
- ☐ Surgical Report
- ☐ CT Scan / MRI / Radiological reports
- ☐ Blood and laboratory test results
- ☐ Other reports. Please give details: _____

1. Are you the Person Covered's usual medical attendant? ☐ Yes ☐ No

   If "YES", since what date? | | / | | / | | | | (dd/mm/yyyy)

2. Has the Person Covered previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?

   ☐ Yes ☐ No

   If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name and Address of Clinic / Hospital

3. Date when Person Covered FIRST consulted you for Cancer. | | / | | / | | | | (dd/mm/yyyy)

4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Person Covered had been experiencing these symptoms.

Symptoms	Date symptoms first started (dd/mm/yyyy)
(a)	
(b)	

What is the source of this information?

- ☐ Patient
- ☐ Referring doctor
  Name of doctor and hospital / clinic: _____
- ☐ Others, please specify: _____

5. Diagnosis
   - (i) Please describe the full and exact diagnosis. (i) _____
   - (ii) Date when Cancer was FIRST diagnosed. (ii) | | / | | / | | | | (dd/mm/yyyy)
   - (iii) Diagnosis was FIRST made by (name of doctor and hospital) (iii) _____
   - (iv) Date when Person Covered FIRST became aware of the illness. (iv) | | / | | / | | | | (dd/mm/yyyy)

6. (i) What was the site or organ involved? (i) _____
   (ii) What was the precise histology of the tumour? (ii) _____

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(iii) What was the staging of the tumour?
Please provide full details using appropriate staging classification (e.g. TNM, FIGO, Ann Arbor, Duke's etc.)

(iii) _____

_____

(iv) It is classified as:

☐ borderline malignancy ☐ carcinoma in-situ
☐ having low malignant potential ☐ non-invasive
☐ having high malignant potential ☐ invasive
☐ pre-malignant

(v) The disease was:
You may tick (√) more than one.

☐ invasive to adjacent tissues ☐ completely localized
☐ involved regional lymph nodes
☐ distant metastatic. If so, please give details

_____

7. Type of investigations / tests done to confirm the diagnosis.

☐ Biopsy / Histopathology ☐ Tumour marker test
☐ Bone marrow aspiration / Trephine
☐ Others, please specify: _____

8. Please provide full details of all treatments provided.

Treatment	Type and details	Treatment Commencement Date
Surgery		
Radiotherapy		
Chemotherapy		
Others, please specify:		

9. Please provide the full address of any hospitals to which the Person Covered has been referred together with the names of the consultant attended.

Hospital	Address	Name of consultant	Date of consultation

10. Is the Cancer associated with HIV or AIDS?

☐ Yes ☐ No

If "YES", please state the date HIV was first diagnosed / detected.

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

11. Has the Person Covered previously suffered from or detected to have raised tumour marker, abnormal PAP smear, benign tumour, pre-malignant condition, cancer, hypertension, diabetes, hyperlipidaemia, cardiovascular diseases or any other significant illnesses?

☐ Yes ☐ No

If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Name of Doctor	Name and Address of Clinic / Hospital

12. Please provide us with any other information that will enable the Takaful Operator to assess this claim.

_____

_____

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and that I have answered the above questions are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name: _____

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)