CONFIDENTIAL MEDICAL CERTIFICATE
(CRITICAL ILLNESS - HEART RELATED CONDITIONS)

Great Eastern TAKAFUL

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

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

Old NRIC/Birth Certificate/ Passport 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 within the coverage of a Critical Illness benefit 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)

Section 1: This section is COMPULSORY to be completed for all Critical Illnesses

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 the illness. | | / | | / | | | | (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 presented (dd/mm/yyyy)
(a)	
(b)	

What is the source of this information?

☐ Person Covered
☐ Referring doctor
Name of doctor and hospital / clinic: _____
☐ Others, please specify: _____

5. Diagnosis
   (i) Please describe the full and exact diagnosis. (i) _____
   (ii) Date and time when the illness was FIRST diagnosed (ii) | | / | | / | | | | (dd/mm/yyyy) _____ a.m. / p.m.
   (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. Type of investigations / tests done to confirm the diagnosis. _____

7. Please give details of completed, planned or current treatment for the illness stated above. _____

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8. Is there any heart failure / cardiac impairment at present (at the time of completion of this report)? If '"YES": (i) Please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification (ii) Is the cardiac impairment likely to be permanent? (iii) Will the cardiac impairment improve?	☐ Yes ☐ No (i) Class ☐ I ☐ II ☐ III ☐ IV Please provide details of current limitations _____ (ii) ☐ Yes ☐ No (iii) ☐ Yes ☐ No

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

_____

_____

Section 2: This section is applicable to specific Critical Illness only

A. To Be Completed for:

- **Heart Attack / Myocardial Infarction (MI), OR**
- **Coronary Artery By-pass Surgery, OR**
- **Other Serious Coronary Artery Disease, OR**
- **Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease**
- **Severe Cardiomyopathy, OR**
- **Primary Pulmonary Arterial Hypertension, OR**

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

☐ All serial Electrocardiogram (ECG)
☐ All Cardiac Enzymes (CPK-MB, Troponin T/ Troponin I)
☐ Echocardiogram report
☐ Percutaneous Coronary Intervention (PCI) or Laser treatment report
☐ Other reports. Please give details: _____
☐ Coronary angiogram report
☐ Coronary Artery By-pass Graft operation report
☐ Cardiac catheterization report

1. For illness of Heart Attack / Myocardial Infarction, please give the details of investigations / tests done that confirm the diagnosis.

	Date and time	Investigations / tests result
Cardiac marker (CK / CPK-MB / Troponin T or I)		
ECG		
ECHO / Others:		

2. Please complete the following:

(i) Please specify the coronary arteries involved and the percentage of stenosis:

Major Coronary Artery	Stenosis		Percentage (%) of stenosis
	YES	NO	
Left Main Stem			
Left Anterior Descending Artery			
Left Circumflex Artery			
Right Coronary Artery			
If other than above, please specify in details: _____ _____			

Please give details of procedure / surgery performed.

(ii)

Tick (√)	Procedure/ surgery performed	Date and time of the surgery	Name of doctor who performed surgery, hospital & address
☐	Coronary Artery By-pass Graft via open-chest surgery		
☐	Percutaneous Coronary Intervention (PCI)		
☐	Others, please specify:		

3. Please complete the questions if the Person Covered have cardiomyopathy or primary pulmonary hypertension:	
(i) Details of investigations performed to confirm the diagnosis.	(i) _____
(ii) What is the underlying cause of the cardiomyopathy / pulmonary hypertension?	(ii) _____
(iii) Since when did the Person Covered have the underlying cause?	(iii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(iv) Is the cardiomyopathy due to alcohol or drug misuse / abuse?	(iv) ☐ Yes ☐ No If "YES", please provide details. _____

B. To Be Completed for:
- **Heart Valve Surgery, OR**
- **Surgery to Aorta**

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

☐ Heart valve surgery report
☐ Aortic surgery report
☐ Echocardiogram report
☐ Angiogram report
☐ Other reports. Please give details: _____

1. Type of surgery performed	_____ _____
2. Date of surgery	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
3. Name of doctor who performed the surgery, with name of hospital and address	_____ _____ _____
4. For Heart valve surgery:	
(i) The approach was via :	(i) ☐ open heart surgery ☐ intra-arterial procedure ☐ key-hole procedure ☐ others : _____
(ii) The procedure done was:	(ii) ☐ valvotomy / valvuloplasty ☐ valve repair ☐ valve replacement
5. For Surgery to aorta:	
(i) The approach was via :	(i) ☐ thoracotomy ☐ catheter based techniques ☐ laparotomy ☐ key-hole procedure ☐ intra-arterial procedure
(ii) The surgery was performed for :	(ii) ☐ aneurysm ☐ obstruction ☐ dissection ☐ coarctation ☐ others : _____
(iii) The surgery was performed at :	(iii) ☐ thoracic aorta ☐ abdominal aorta ☐ aortic branches : _____

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)