TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT

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 within the coverage of a Total and Permanent Disability 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)

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 been detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder, pre-malignant condition, cancer 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. (i) Date when Person Covered FIRST consulted you for the illness. (i) | | / | | / | | | | (dd/mm/yyyy)

   (ii) Date(s) of subsequent consultation(s) / follow up(s) (ii) _____

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 when the illness 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)

   (v) Date when diagnosis was first made to the Person Covered. (v) | | / | | / | | | | (dd/mm/yyyy)

   (vi) What was the exact information conveyed to the Person Covered? (vi) _____

   (vii) What is the underlying cause of the illness for the diagnosis above? (vii) _____

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6. (i) Type of investigations / tests done to confirm the diagnosis

(i) _____

(ii) Type of treatments given and his / her response to the treatments.

(ii) _____

7. (i) Person Covered's occupation before disability

(i) _____

(ii) Nature of duties of the occupation in 7 (i)

(ii) _____

(iii) How does the Person Covered's disability prevent him / her from performing the above listed duties of his / her occupation?

(iii) _____

8. Did the Person Covered consult other doctors for this condition or its symptoms BEFORE he / she consulted you?

☐ Yes ☐ No

If "YES", please provide the following:

Name of Doctor	Name of Clinic/Hospital and Address	Date of First Consultation

Question 9 to be completed if disability caused by an accident

9. (i) Is the condition a result of an accident?

(i) ☐ Yes ☐ No

If "YES", please state the date of accident

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) Describe in detail how the accident happened

(ii) _____

(iii) Was the Person Covered under the influence of alcohol / drug at the time of accident?

(iii) ☐ Yes ☐ No

If "YES", please state the blood alcohol content/drug type and quantity consumed.

_____

(iv) Is the condition self-inflicted?

(iv) ☐ Yes ☐ No

If "YES", please provide full details

_____

Please complete the **Question 11 to 20** based on your latest detailed examination at the date in **Question 10.**

10. Last examination / consultation date

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

11. Please describe fully the nature of the Person Covered's disabilities.

_____

12. Vision (Visual Acuity)

	Right	**Left**
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

13. Hearing

	Right	**Left**
Normal		
Impaired		
Scores based on speech reception threshold	dB	dB

(Supported by an Audiometry results)

Remarks: _____

14. Function of speech

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Remarks: _____

15. Cognitive function

☐ Normal
☐ Poor comprehension
☐ Difficult with logic and reasoning
☐ Memory loss

Remarks: _____

16. General examination findings:

(i) Are there any abnormal movements or abnormal gait? (Please provide full details) — (i) _____

(ii) Is there any muscle wasting? (Please provide full details) — (ii) _____

(iii) If there are any other significant examination findings, please provide the details. — (iii) _____

17. Examination of the Limbs

(i) Please indicate the muscle power of the various joint in the table below with the maximum grade of 5.

Upper Limbs	**Right**	**Left**
Shoulder		
Elbow		
Wrist		
Grip		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

Remarks: _____

(ii) Please indicate the Range of Movement of the various joint in the table below.

Upper Limbs	**Right**	**Left**
Shoulder		
Elbow		
Wrist		
Finger(s)		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

Remarks: _____

18. Assessment of Activities of Daily Living

Activities of Daily Living	**Not Limited**	**Limited**	**Incapable**
Transfer (Getting in & out of a chair without physical assistance)			
Mobility (Ability to move from room to room without physical assistance)			
Continence (Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene)			
Dressing (Putting on & taking off all necessary items of clothing without assistance of another person)			
Bathing / **Washing** (Ability to wash in the bath or shower, including getting in & out of bath or shower or wash by any other means without assistance of another person)			
Eating (All task of getting food into the body without assistance of another person)			

19. (i) Is Person Covered's disability progressively worsening, stagnant or recovering?

(i) _____

(ii) Is full recovery expected?

(ii) ☐ Yes ☐ No

If "YES", please state approximate period taken for full recovery from now.

_____

If "NO", please state the extent of recovery and approximate period taken for the stated extent of recovery from now.

_____

_____

(iii) Is Person Covered confined to a home, hospital or other institution that provides constant care and medical attention?

(iii) _____

If "YES", since what date?

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

20. (i) Is the Person Covered able to perform all the normal duties of his / her usual occupation?

(i) ☐ Yes ☐ No

If "YES", when is he/she expected to return to his/her usual occupation?

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) If he / she is unable to return to his/her usual occupation, is he / she able to engage in any other occupation?

(ii) ☐ Yes ☐ No

(a) What types of occupation can he / she be engaged in?

(a) _____

(b) When is he / she expected to engage in these occupations?

(b) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

21. Is the Person Covered physically or mentally incapacitated from ever continuing in any employment?

☐ Yes ☐ No

If "YES", when did such disability commence?

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

22. Is the Person Covered certified to be Total and Permanent Disabled?

☐ Yes ☐ No

(i) If "YES", when did the Person Covered certified to be Total and Permanent Disabled?

(i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) If the incapacity of the Person Covered cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future?

(ii) ☐ Yes ☐ No

If "YES", when is the next review / examination of the condition scheduled?

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

23. Please provide us with any other additional information that will enable the Takaful Operator to assess this claim. Please enclose copies of laboratory test result, if any.

_____

_____

_____

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.

Name: _____

Address:

Signature and Official Stamp

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)