

**CONFIDENTIAL MEDICAL CERTIFICATE
(CRITICAL ILLNESS - OTHER ILLNESSES)**



Certificate No.	<input type="text"/>	New NRIC No.	<input type="text"/> - <input type="text"/> - <input type="text"/>
Certificate No.	<input type="text"/>	Old NRIC/Birth Certificate/ Passport No.	<input type="text"/>
Certificate No.	<input type="text"/>	Name of Person Covered	_____
Certificate No.	<input type="text"/>		

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 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)

Claims Condition Suffered (Please tick (/) where applicable)

- | | | |
|--|---|--|
| <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Fulminant Hepatitis | <input type="checkbox"/> Major Organ Transplant |
| <input type="checkbox"/> Total Permanent Blindness | <input type="checkbox"/> End Stage Liver Disease | <input type="checkbox"/> Terminal Illness |
| <input type="checkbox"/> Total Permanent Deafness | <input type="checkbox"/> End Stage Lung Disease | <input type="checkbox"/> Aplastic Anaemia |
| <input type="checkbox"/> Loss of Speech | <input type="checkbox"/> HIV Infection From Blood Transfusion | <input type="checkbox"/> Full Blown AIDS |
| <input type="checkbox"/> Major Burns | <input type="checkbox"/> AIDS Cover of Medical Staffs | <input type="checkbox"/> Loss of Independent Existence |
| <input type="checkbox"/> Systemic Lupus Erythematosus (SLE) with Lupus Nephritis | | |

1. Are you the Person Covered's usual medical attendant?
If "YES", since what date?

Yes No

/ / (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 when the illness was FIRST diagnosed.	(ii) <input type="text"/> / <input type="text"/> / <input type="text"/> (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) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
(v) What is the underlying cause of the illness as per diagnosis above?	(v) _____

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Great Eastern Takaful Berhad (916257-H)

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(vi) When was the underlying cause FIRST diagnosed?	(vi) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy) Name of treating doctor and clinic / hospital. <hr/> <hr/> <hr/>
6. Type of investigations / tests done to confirm the diagnosis.	<hr/> <hr/> <hr/>
7. Please give details of completed, planned or current treatment for the illness stated above.	<hr/> <hr/> <hr/>
8. What is the current condition of the Person Covered and what is the prognosis?	<hr/> <hr/> <hr/>
9. Please provide us with any other information that will enable the Takaful Operator to assess this claim. <hr/> <hr/> <hr/>	

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)