

**TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT**



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"/>		
Certificate No.	<input type="text"/>	Name of Person Covered	<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 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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) <input type="text"/>	<input type="text"/>
(b) <input type="text"/>	<input type="text"/>

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) <input type="text"/>
(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) <input type="text"/>
(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) Date when diagnosis was first made to the Person Covered.	(v) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
(vi) What was the exact information conveyed to the Person Covered?	(vi) <input type="text"/>
(vii) What is the underlying cause of the illness for the diagnosis above?	(vii) <input type="text"/>

CLM-TPDDS-V03-042015-TAKAFUL

Great Eastern Takaful Berhad (916257-H)

Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Telephone: +603 4259 8338 Fax: +603 4259 8808 Customer Service Careline: 1 300 13 8338
E-mail: i-greatcare@i-great.com.my Website: www.i-great.com

6. (i) Type of investigations / tests done to confirm the diagnosis (ii) Type of treatments given and his / her response to the treatments.	(i) _____ _____ (ii) _____ _____
7. (i) Person Covered's occupation before disability (ii) Nature of duties of the occupation in 7 (i) (iii) How does the Person Covered's disability prevent him / her from performing the above listed duties of his / her occupation?	(i) _____ _____ (ii) _____ _____ (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? (ii) Describe in detail how the accident happened (iii) Was the Person Covered under the influence of alcohol / drug at the time of accident? (iv) Is the condition self-inflicted?	(i) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please state the date of accident <div style="border: 1px solid black; display: inline-block; padding: 2px;"> / / (dd/mm/yyyy) </div> (ii) _____ _____ (iii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please state the blood alcohol content/drug type and quantity consumed. _____ (iv) <input type="checkbox"/> Yes <input type="checkbox"/> 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	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> / / (dd/mm/yyyy) </div>												
11. Please describe fully the nature of the Person Covered's disabilities.	_____ _____												
12. Vision (Visual Acuity)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> </tr> </thead> <tbody> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on Metric Acuity</td> <td> </td> <td> </td> </tr> </tbody> </table> <p>Remarks: _____</p>		Right	Left	Normal			Impaired			Scores based on Metric Acuity		
	Right	Left											
Normal													
Impaired													
Scores based on Metric Acuity													
13. Hearing	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;"></th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> </tr> </thead> <tbody> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on speech reception threshold</td> <td style="text-align: center;">dB</td> <td style="text-align: center;">dB</td> </tr> </tbody> </table> <p style="text-align: center;">(Supported by an Audiometry results)</p> <p>Remarks: _____</p>		Right	Left	Normal			Impaired			Scores based on speech reception threshold	dB	dB
	Right	Left											
Normal													
Impaired													
Scores based on speech reception threshold	dB	dB											
14. Function of speech	<input type="checkbox"/> Clear and understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Unable to speak Remarks: _____												
15. Cognitive function	<input type="checkbox"/> Normal <input type="checkbox"/> Poor comprehension <input type="checkbox"/> Difficult with logic and reasoning <input type="checkbox"/> 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)			

<p>19. (i) Is Person Covered's disability progressively worsening, stagnant or recovering? (ii) Is full recovery expected?</p> <p>(iii) Is Person Covered confined to a home, hospital or other institution that provides constant care and medical attention? If "YES", since what date?</p>	<p>(i) _____</p> <p>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> 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. _____ _____</p> <p>(iii) _____ _____ _____ _____ _____ _____ _____ (dd/mm/yyyy)</p>
---	---

<p>20. (i) Is the Person Covered able to perform all the normal duties of his / her usual occupation?</p> <p>(ii) If he / she is unable to return to his/her usual occupation, is he / she able to engage in any other occupation? (a) What types of occupation can he / she be engaged in? (b) When is he / she expected to engage in these occupations?</p>	<p>(i) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", when is he/she expected to return to his/her usual occupation? _____ _____ (dd/mm/yyyy)</p> <p>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> No (a) _____ (b) _____ (dd/mm/yyyy)</p>
---	---

<p>21. Is the Person Covered physically or mentally incapacitated from ever continuing in any employment?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", when did such disability commence? _____ _____ (dd/mm/yyyy)</p>
---	---

<p>22. Is the Person Covered certified to be Total and Permanent Disabled? (i) If "YES", when did the Person Covered certified to be Total and Permanent Disabled? (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?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (i) _____ (dd/mm/yyyy) (ii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", when is the next review / examination of the condition scheduled? _____ _____ (dd/mm/yyyy)</p>
---	---

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: _____

Date: _____ (dd/mm/yyyy)

Signature and Official Stamp