MikroSayang Great Eastern TAKAFUL

CI-04 DOCTOR'S STATEMENT - CRITICAL ILLNESS - EYES, EARS & SPEECH

CI-04

MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST
Please attach copies of ALL relevant hospital / operation reports, laboratory and test results.
For any medical report fee incurred in completing this form, it will be borne by Person Covered.

Name of Patient (Person Covered)

New NRIC No. ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐

Diagnosis	
(i) Please describe the full and exact diagnosis.	(i) _____
(ii) Date when the illness was FIRST diagnosed?	(ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(iii) It was due to	(iii) ☐ Illness ☐ Accident
(iv) Please provide details of the accident/ medical conditions	(iv) _____
(v) Has the patient previously had the same or similar condition?	(v) ☐ Yes ☐ No If "Yes", please state the first treatment date ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Please state symptoms or condition presented: _____

Blindness - Permanent and Irreversible

1 What is the best **corrected** visual acuity of both eyes at present:	1 Date of test: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Right: _____ Left: _____
2 (i) Is the loss of vision considered total, permanent and irreversible?	2 (i) ☐ Yes ☐ No ☐ Others: _____
(ii) If "YES", please provide the date when loss of vision was certified as total, permanent and irreversible:	(ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Deafness - Permanent and Irreversible

1 Please complete the following:	
(i) What is the best **corrected** hearing frequency of both ears at present:	(i) Date of test: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Frequency	Right ear (dB)	Left ear (dB)
1000 Hz		
2000 Hz		
3000 Hz		

(ii) Was the above test done using a hearing aid?	(ii) ☐ Yes ☐ No
(iii) Can the hearing be improved with the use of a hearing aid?	(iii) ☐ Yes ☐ No
(iv) Has a hearing aid been recommended to the Person Covered?	(iv) ☐ Yes ☐ No
(v) If a hearing aid was not recommended, please give details as to why it was not recommended	(v) _____
2 (i) Is the loss of hearing considered total, permanent and irreversible?	2 (i) ☐ Yes ☐ No
(ii) If "YES", please provide the date when loss of hearing was certified as total, permanent and irreversible:	(ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Great Eastern Takaful Berhad (916257-H)
Head Office: MikroSayang, Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 03-4259 8350 Fax: +603 4259 8808
E-mail: mikrosayang@greateasterntakaful.com Website: www.mikrosayang.com

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Loss of Speech ***(A minimum Assessment Period of 6 months applies)***

1	Is the loss of speech related to the psychiatric disorder?	1 ☐ Yes ☐ No
2	(i) Was the inability to speak related to the vocal cord?	2 (i) ☐ Yes ☐ No
	(ii) Please name nature of the disease/ injury to the vocal cord	(ii) _____
3	What was the duration of loss of speech?	
	(i) A continuous period of less than 6 months	3 (i) ☐ Yes ☐ No
	(ii) A continuos period of more than 6 months	(ii) ☐ Yes ☐ No
4	(i) Is patient loss of ability to speak total, permanent and irreversible?	4 (i) ☐ Yes ☐ No
	(ii) If "YES", please provide the date when loss of speech was certified as total, permanent and irreversible:	(ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and all statement made and answers given are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name: _____

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)