Great Eastern TAKAFUL X PERLINDUNGAN tenang MAMPU & MUDAH

CI-09 | DOCTOR'S STATEMENT - CRITICAL ILLNESS - TERMINAL ILLNESS

MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

CI-09

Certificate No.

New NRIC No. - -

Certificate No.

Name of Patient (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 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)

1 Declaration to be completed by Attending Physician/ Specialist

I hereby certify that :

☐ I am the patient's attending doctor, and I have personally examined and treated the patient for the illnesses and injuries sustained; OR

☐ This medical report has been prepared on behalf of the treating doctor based on medical records.

Name:

Signature and Official Stamp

2 Medical History

(i) 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 & Address of Clinic / Hospital

3 Diagnosis

(i) Please describe the full and exact diagnosis	
(ii) Date when the illness was FIRST diagnosed	/ / (DD/MM/YYYY)
(iii) Date when Person Covered FIRST became aware of the illness	/ / (DD/MM/YYYY)

Great Eastern Takaful Berhad 201001032332 (916257-H)
Head Office: 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

 6477049276

(iv) What is the underlying cause of the illness as per diagnosis above?	
(v) Date when the underlying cause in (iv) was FIRST diagnosed?	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(vi) Please state the symptoms presented during the date of FIRST consultation
(Please indicate what had prompted the Person Covered to see you).

Symptoms	Date symptoms first started (dd/mm/yyyy)	Based on your professional opinion, what is the duration of symptoms presented prior to first consultation?

What is the source of this information?

☐ Patient

☐ Referring doctor / hospital. Please state:

Hospital	Address	Name of Consultant	Date of Consultation

☐ Others, please specify:

_____

(vii) Date when patient/ patient's next of kin was informed that the illness was terminal:	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
(viii) In your opinion, is the patient's illness / condition terminal?	☐ Yes ☐ No
(ix) Is the patient's condition incurable and cannot be adequately treated to recover?	☐ Yes ☐ No If "Yes", please provide your basis. _____
(x) In your opinion, what is the estimated life expectancy of the patient?	_____ months
(xi) Has active therapy now been rejected in favour of palliative care?	☐ Yes ☐ No If "Yes", please elaborate _____

End-Stage Lung Disease

(xii) What treatment is the patient currently receiving?
Please tick which is applicable.

☐ Transplant Date of transplant ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

☐ Chemotherapy/Radiotherapy

☐ Physiotherapy

☐ Palliative care

☐ Medication(s)

Please list down all medication prescribed to the patient now.

Note:
Please enclose copies of all reports that are available with you (including Radiological, CT Scanning, Imaging Reports, Blood and laboratory test results, Surgical Report for Major Organ Transplant and any relevant reports). If not submitted, company reserves the right to defer for further verification.

Declaration to be completed by Attending Physician/ Specialist

I, the undersigned, certify that I confirmed all statements 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)