CONFIDENTIAL MEDICAL CERTIFICATE
(CRITICAL ILLNESS - BRAIN, NERVE & MUSCLE RELATED CONDITION)

Certificate No. | | | | | | | | | |

Certificate No. | | | | | | | | | |

Certificate No. | | | | | | | | | |

Certificate No. | | | | | | | | | |

New NRIC No. | | | | | | | | | | | | | | |

Old NRIC/Birth Certificate/ Passport 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 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)

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

- ☐ CT Scan / MRI report of the Brain
- ☐ MRI of Spine
- ☐ Lumbar puncture test report
- ☐ Electromyography (EMG) test results
- ☐ Nerve conduction study/ Evoked potential test
- ☐ Other reports. Please give details: _____
- ☐ Blood test reports
- ☐ Surgery report
- ☐ Histopathology examination (HPE)
- ☐ Biopsy report

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 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) (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)

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6. What is the underlying cause of the illness as per diagnosis above?	
7. Type of investigations / tests done to confirm the diagnosis.	
8. Please give details of completed, planned or current treatment for the illness stated above.	
9. Is the Critical Illness associated with any other disorder, for example neurosis, psychiatric illness, HIV infection, etc.?	☐ Yes ☐ No If "YES", please give details.
10. The condition was associated with: (Please elaborate in details)	☐ self-inflicted injury ☐ drug or alcohol misuse ☐ Others:

11. Please tick and complete for the relevant sections:

☑ Please tick	Items	Descriptions
☐ Stroke	Cause of stroke:	☐ Infarct ☐ Hemorrhage ☐ Embolus
☐ Parkinson's Disease	(i) Cause of Parkinson's Disease: (ii) Can the condition / illness be controlled with medication?	(i) ☐ Idiopathic ☐ Secondary due to: _____ (ii) ☐ Yes ☐ No
☐ Motor Neuron Disease	Type of Motor Neuron Disease:	☐ Amyotrophic lateral sclerosis ☐ Progressive bulbar palsy ☐ Primary lateral sclerosis ☐ Spinal muscular atrophy
☐ Muscular Dystrophy	Type of Muscular Dystrophy:	☐ Duchenne's ☐ Myotonic ☐ Facioscapulohumeral ☐ Congenital ☐ Others: _____
☐ Alzheimer's Disease	Type of conditions involved:	☐ Alzheimer's disease ☐ Dementia ☐ Other degenerative brain disorders
☐ Major Head Trauma	What is the exact location and extent of the head injury?	
☐ Coma	(i) How long was the Person Covered in a state of coma, with no response to external stimuli? (ii) Was the coma 'Medically induced'? (iii) How long was the Person Covered on a ventilator?	(i) _____ hours / _____ days since (dd/mm/yyyy) -Please Select (ii) ☐ Yes ☐ No (iii) _____ hours / _____ days First on ventilation since : (dd/mm/yyyy)
☐ Benign Brain Tumour	(i) Is the tumour life threatening? (ii) Are there signs of increased intracranial pressure? (iii) Has it caused damage to the brain?	(i) ☐ Yes ☐ No If "YES", please give details. _____ (ii) ☐ Yes ☐ No If "YES", please give details. _____ (iii) ☐ Yes ☐ No If "YES", please give details. _____

√ Please tick	Items	Descriptions
☐ Bacterial Meningitis / Encephalitis	Please provide Cerebrospinal Fluid (CSF) test results	
☐ Brain Surgery	(i) Please state type of surgery: (ii) Reason for surgery: (iii) Was the surgery done due to injuries sustained during an accident? (iv) Please state date of surgery:	(i) ☐ Craniotomy ☐ Craniectomy ☐ Other procedure : _____ (ii) _____ (iii) ☐ Yes ☐ No (iv) (dd/mm/yyyy)

12. Please provide us with any other information that will enable the Takaful Operator to assess this claim.

13. **Neurological Examination report:**

Please state below **(Question a - h)**, the Person Covered's physical and neurological impairments, **based on latest / current assessment:**

Date when neurological impairments were first noted: (dd/mm/yyyy)

Date of latest/current assessment: (dd/mm/yyyy)

(a) Vision (Visual Acuity)

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

Remarks: _____

(b) Hearing (Supported by an Audiometry results)

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

Remarks: _____

(c) Function of speech

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Remarks: _____

(d) Cognitive function

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

Remarks: _____

(e) 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)

(f) Examination of the Limbs

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

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

(g) 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)	☐	☐	☐

(h) Any other significant neurological examination findings or disability details that are not stated above:

14. What is the prognosis of the Person Covered's neurological impairments? You may tick (√) more than one.	☐ Recovered ☐ Stable and improving ☐ Progressively worsening ☐ No change. Likely to be permanent ☐ For Multiple sclerosis - History of multiple exacerbations and remissions. Please indicate number of exacerbations since diagnosis:

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)