# CONFIDENTIAL MEDICAL CERTIFICATE (CRITICAL ILLNESS - CANCER)

Great Eastern TAKAFUL

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

Certificate No. | | | | | | | | | | | Old NRIC/Birth Certificate/ Passport No. | | | | | | | | | | | | | | | |

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

Certificate 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 in connection with **CANCER** 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 or tests available.**

- ☐ Histopathology examination (HPE) / Biopsy report
- ☐ Bone marrow aspiration / trephine biopsy report
- ☐ Surgical Report
- ☐ CT Scan / MRI / Radiological reports
- ☐ Blood and laboratory test results
- ☐ Other reports. Please give details: _____

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 Cancer. (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 started (dd/mm/yyyy) |
|---|---|
| (a) | |
| (b) | |

What is the source of this information?

- ☐ Patient
- ☐ 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 Cancer 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)

6. (i) What was the site or organ involved? (i) _____
   (ii) What was the precise histology of the tumour? (ii)



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 ***3515084163***

(iii) What was the staging of the tumour?
Please provide full details using appropriate staging classification (e.g. TNM, FIGO, Ann Arbor, Duke's etc.)

(iii)

(iv) It is classified as:

borderline malignancy having low malignant potential
having high malignant potential
pre-malignant

carcinoma in-situ
non-invasive
invasive

(v) The disease was:
You may tick (√ ) more than one.

☐ invasive to adjacent tissues ☐ completely localized
☐ involved regional lymph nodes
☐ distant metastatic. If so, please give details

7. Type of investigations / tests done to confirm the diagnosis.

☐ Biopsy / Histopathology ☐ Tumour marker test
☐ Bone marrow aspiration / Trephine
☐ Others, please specify: _____

8. Please provide full details of all treatments provided.

| Treatment | Type and details | Treatment Commencement Date |
|---|---|---|
| Surgery | | |
| Radiotherapy | | |
| Chemotherapy | | |
| Others, please specify: | | |

9. Please provide the full address of any hospitals to which the Person Covered has been referred together with the names of the consultant attended.

| Hospital | Address | Name of consultant | Date of consultation |
|---|---|---|---|
| | | | |
| | | | |

10. Is the Cancer associated with HIV or AIDS?

☐ Yes ☐ No

If "YES", please state the date HIV was first diagnosed / detected.

(dd/mm/yyyy)

11. Has the Person Covered previously suffered from or detected to have raised tumour marker, abnormal PAP smear, benign tumour, pre-malignant condition, cancer, hypertension, diabetes, hyperlipidaemia, cardiovascular diseases or any other significant illnesses?

☐ Yes ☐ No

If "YES", please provide the following:

| Medical Condition | Date of Diagnosis | Name of Doctor | Name and Address of Clinic / Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

**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)