

**CONFIDENTIAL MEDICAL CERTIFICATE
(CRITICAL ILLNESS - HEART RELATED CONDITIONS)**



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"/>	Name of Person Covered	_____
Certificate No.	<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 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)

Section 1: This section is COMPULSORY to be completed for all Critical Illnesses

1. Are you the Person Covered's usual medical attendant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If "YES", since what date?		<input type="text"/> / <input type="text"/> / <input type="text"/> (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?				
<input type="checkbox"/> Yes <input type="checkbox"/> 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.		<input type="text"/> / <input type="text"/> / <input type="text"/> (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?				
<input type="checkbox"/> Person Covered				
<input type="checkbox"/> Referring doctor				
Name of doctor and hospital / clinic: _____				
<input type="checkbox"/> Others, please specify: _____				
5. Diagnosis		(i) _____		
(i) Please describe the full and exact diagnosis.				
(ii) Date and time when the illness was FIRST diagnosed		(ii) _____ (dd/mm/yyyy) a.m. / p.m.		
(iii) Diagnosis was FIRST made by (name of doctor and hospital)		(iii) _____		
(iv) Date when Person Covered FIRST became aware of the illness.		(iv) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)		
6. Type of investigations / tests done to confirm the diagnosis.		_____		
7. Please give details of completed, planned or current treatment for the illness stated above.		_____		

CLM-LAMHC-V04-052022-TAKAFUL

Great Eastern Takaful Berhad (916257-H)

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<p>8. Is there any heart failure / cardiac impairment at present (at the time of completion of this report)? If "YES":</p> <p>(i) Please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification</p> <p>(ii) Is the cardiac impairment likely to be permanent?</p> <p>(iii) Will the cardiac impairment improve?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(i) Class <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV Please provide details of current limitations _____</p> <p>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(iii) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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9. Please provide us with any other information that will enable the Takaful Operator to assess this claim.

Section 2: This section is applicable to specific Critical Illness only

A. To Be Completed for:

<ul style="list-style-type: none"> - Heart Attack / Myocardial Infarction (MI), OR - Coronary Artery By-pass Surgery, OR - Other Serious Coronary Artery Disease, OR - Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease 	<ul style="list-style-type: none"> - Severe Cardiomyopathy, OR - Primary Pulmonary Arterial Hypertension, OR
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Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

<input type="checkbox"/> All serial Electrocardiogram (ECG)	<input type="checkbox"/> Coronary angiogram report
<input type="checkbox"/> All Cardiac Enzymes (CPK-MB, Troponin T/ Troponin I)	<input type="checkbox"/> Coronary Artery By-pass Graft operation report
<input type="checkbox"/> Echocardiogram report	<input type="checkbox"/> Cardiac catheterization report
<input type="checkbox"/> Percutaneous Coronary Intervention (PCI) or Laser treatment report	
<input type="checkbox"/> Other reports. Please give details: _____	

1. For illness of Heart Attack / Myocardial Infarction, please give the details of investigations / tests done that confirm the diagnosis.

	Date and time	Investigations / tests result
Cardiac marker (CK / CPK-MB / Troponin T or I)		
ECG		
ECHO / Others:		

2. Please complete the following:

(i) Please specify the coronary arteries involved and the percentage of stenosis:

Major Coronary Artery	Stenosis		Percentage (%) of stenosis
	YES	NO	
Left Main Stem			
Left Anterior Descending Artery			
Left Circumflex Artery			
Right Coronary Artery			
If other than above, please specify in details: _____ _____			

Please give details of procedure / surgery performed.

(ii)

Tick (✓)	Procedure/ surgery performed	Date and time of the surgery	Name of doctor who performed surgery, hospital & address
<input type="checkbox"/>	Coronary Artery By-pass Graft via open-chest surgery		
<input type="checkbox"/>	Percutaneous Coronary Intervention (PCI)		
<input type="checkbox"/>	Others, please specify:		

<p>3. Please complete the questions if the Person Covered have cardiomyopathy or primary pulmonary hypertension:</p> <p>(i) Details of investigations performed to confirm the diagnosis.</p> <p>(ii) What is the underlying cause of the cardiomyopathy / pulmonary hypertension?</p> <p>(iii) Since when did the Person Covered have the underlying cause?</p> <p>(iv) Is the cardiomyopathy due to alcohol or drug misuse / abuse?</p>	<p>(i) _____</p> <p>(ii) _____</p> <p>(iii) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)</p> <p>(iv) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please provide details.</p> <p>_____</p>
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B. To Be Completed for:
- Heart Valve Surgery, OR
- Surgery to Aorta

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

Heart valve surgery report Echocardiogram report
 Aortic surgery report Angiogram report
 Other reports. Please give details: _____

1. Type of surgery performed	_____
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2. Date of surgery	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)
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3. Name of doctor who performed the surgery, with name of hospital and address	_____
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<p>4. For Heart valve surgery:</p> <p>(i) The approach was via :</p> <p>(ii) The procedure done was:</p>	<p>(i) <input type="checkbox"/> open heart surgery <input type="checkbox"/> intra-arterial procedure <input type="checkbox"/> key-hole procedure <input type="checkbox"/> others : _____</p> <p>(ii) <input type="checkbox"/> valvotomy / valvuloplasty <input type="checkbox"/> valve repair <input type="checkbox"/> valve replacement</p>
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<p>5. For Surgery to aorta:</p> <p>(i) The approach was via :</p> <p>(ii) The surgery was performed for :</p> <p>(iii) The surgery was performed at :</p>	<p>(i) <input type="checkbox"/> thoracotomy <input type="checkbox"/> catheter based techniques <input type="checkbox"/> laparotomy <input type="checkbox"/> key-hole procedure <input type="checkbox"/> intra-arterial procedure</p> <p>(ii) <input type="checkbox"/> aneurysm <input type="checkbox"/> obstruction <input type="checkbox"/> dissection <input type="checkbox"/> coarctation <input type="checkbox"/> others : _____</p> <p>(iii) <input type="checkbox"/> thoracic aorta <input type="checkbox"/> abdominal aorta <input type="checkbox"/> aortic branches : _____</p>
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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.

<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p>Signature and Official Stamp</p>	<p>Name: _____</p> <p>Address: _____</p> <p>Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)</p>
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