CONFIDENTIAL MEDICAL CERTIFICATE
(CRITICAL ILLNESS - OTHER ILLNESSES)

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)

Claims Condition Suffered (Please tick (/) where applicable)

- ☐ Kidney Failure
- ☐ Total Permanent Blindness
- ☐ Total Permanent Deafness
- ☐ Loss of Speech
- ☐ Major Burns
- ☐ Systemic Lupus Erythematosus (SLE) with Lupus Nephritis
- ☐ Fulminant Hepatitis
- ☐ End Stage Liver Disease
- ☐ End Stage Lung Disease
- ☐ HIV Infection From Blood Transfusion
- ☐ AIDS Cover of Medical Staffs
- ☐ Major Organ Transplant
- ☐ Terminal Illness
- ☐ Aplastic Anaemia
- ☐ Full Blown AIDS
- ☐ Loss of Independent Existence

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)
(v) What is the underlying cause of the illness as per diagnosis above?	(v)	

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(vi) When was the underlying cause FIRST diagnosed?	(vi) (dd/mm/yyyy) Name of treating doctor and clinic / hospital.
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.	
8. What is the current condition of the Person Covered and what is the prognosis?	
9. 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)