

Issue by:  
Date :

**CONFIDENTIAL MEDICAL CERTIFICATE  
(LIVING ASSURANCE)**

**(To be completed by Doctor)**

**Name of Life Assured:** \_\_\_\_\_

**NRIC No:** \_\_\_\_\_ **Policy No:** \_\_\_\_\_

**Please tick accordingly.**

**Full Blown AIDS**

Clinical manifestation of AIDS (Acquired Immune Deficiency Syndrome), which must be supported by the results of a positive HIV (Human Immunodeficiency Virus) antibody test and a confirmatory Western Blot test. In addition, the Life Assured must have a CD4 cell count of less than 200 and evidence of opportunistic infection and/or AIDS related tumours.

**Occupationally Acquired HIV Infection**

The Life Assured being infected by HIV (Human Immunodeficiency Virus) unequivocally as a result of an accident occurring during the course of carrying out normal occupational duties, with sero-conversion to HIV infection occurring within six (6) months of the accident. Any accident giving rise to a potential claim must be reported to the Company within thirty (30) days of the accident taking place and supported by a negative HIV test taken in Malaysia, Singapore or Brunei within seven (7) days of the accident. Infection in any other manner is specifically excluded.

**HIV Infection from Blood Transfusion**

The Life Assured being infected by Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome provided that:

- (a) the infection is due to a blood transfusion received in Malaysia, Singapore or Brunei;
- (b) the Company, on the advice of the Medical Adviser appointed by the Company is fully satisfied that the infection was due to a blood transfusion given as part of medical treatment after commencement of the Policy;
- (c) the infected Life Assured is not a haemophiliac; and
- (d) the conditions must be life threatening and there exists no known cure.

1. Are you the Life Assured's usual medical attendant? If yes, since when? If no, kindly note the name/ address of his/her usual medical attendant.

\_\_\_\_\_

2. a) Date when Life Assured first consulted you for the above stated condition:

\_\_\_\_\_

b) Symptoms presented: \_\_\_\_\_

c) How long had symptoms been present: \_\_\_\_\_

d) Diagnosis:

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e) Date when illness first diagnosed: \_\_\_\_\_

f) Please state when the diagnosis was first made by you {if the answer is different from (e)}:

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g) When was the Life Assured first detected to be HIV positive? Please state the date.

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h) Please state the mode of transmission of this infection: \_\_\_\_\_

i) What other illnesses or any related illness (i.e. Sexually Transmitted Disease, Hepatitis B or C) has the Life Assured previously suffered. Please give consultation dates, diagnosis and other relevant details pertaining to the illness.

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3. Is the Life Assured on any treatment or follow up? Please give details of the treatment.

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4. Has the claimant ever received a blood transfusion/ blood products or been rejected as a donor? If yes, please give details (i.e. reason, frequency, dates, hospital).

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5. Please attach HIV positive report from the time of initial diagnosis including the confirmatory Western Blot Assay, any other laboratory results including a CD4 count (if any), and all other pertinent reports and results of tests done.

6. **For Full Blown AIDS only:**

Please provide details in respect of the diagnosis on which Full Blown Aids has been established (i.e. diagnosis, date).

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7. **For occupationally acquired HIV infection only:**

Please provide the following information.

- a) Date of accident: \_\_\_\_\_
- b) Nature of occupation at the time of accident: \_\_\_\_\_
- c) Name of hospital/ clinic where the accident occurred: \_\_\_\_\_
- d) Date of first diagnosis to be HIV positive. Please attach the lab report. \_\_\_\_\_

**8. For HIV infection from Blood Transfusion only.**

- a) Is the claimant a haemophilia patient, or does the claimant suffers from any other diseases or conditions which require blood transfusion or have been required for blood transfusion? If yes, please state details (reason, frequency, date, hospital).

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- b) Do you have any knowledge whether the hospital/ blood transfusion centre had any blood charges in the past (i.e. defect of blood product, previous HIV reported cases via blood transfusion etc)? If yes, please indicate.

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**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Name, Address and Official Stamp**

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