

**CONFIDENTIAL MEDICAL CERTIFICATE
(LIVING ASSURANCE)**

Issued By:
Date :

Name of Life Assured:.....

NRIC No. : Policy No. :

The above named is insured with the Great Eastern Life Assurance (Malaysia) Berhad against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **BENIGN BRAIN TUMOUR** and, to enable us to assess the claim, we would be obliged if you would complete this confidential report and return it direct to us in the self-addressed envelope provided.

In order for the claim to be valid the following definition must be fulfilled:-

28. Benign Brain Tumour : A life threatening, non-cancerous tumour in the brain giving rise to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment as confirmed by imaging studies such as CT scan or MRI.
Cysts, granulomas, malformations, in or of the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered.

1. Are you the Life Assured's usual medical attendant? YES NO

If 'yes', over what period do your records extend?

2. (i) Date when Life Assured first consulted you for this illness:.....

(ii) Symptoms presented:

(iii) How long had symptoms been present?

(iv) Diagnosis:

(v) Date when illness was first diagnosed:

(vi) Diagnosis was first made by:

(vii) Date when Life Assured first became aware of the illness:.....

(viii) Please give details of the patient's habits in relation to cigarette smoking.

3. MEDICAL DETAILS

(a) Has the Life Assured previously suffered from the Benign Brain Tumour or any possible related illness?
 YES NO

If 'yes', please give dates of consultations and the resulting diagnosis.

(b) Please provide full and exact details of the diagnosis.

(c) Has the tumour been totally or partially surgically eradicated? If yes, please give details of histology?

(d) Please give the name and address of all consultants, specialists or hospitals to which your patient has been referred or attended for this condition.

(e) We would be grateful for copies of any relevant hospital reports that are available.

(f) In your opinion, does the condition suffered by the Life Assured fulfil the definition stated below?

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YES NO

(g) If there is any further information which, in your opinion, will assist our Chief Medical Officer in assessing this claim, please give details.

Date

Signature

Name, address and Official Stamp

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