CONFIDENTIAL MEDICAL CERTIFICATE (LIVING ASSURANCE)

Great Eastern

Policy No. / *No. Polisi*

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New NRIC No. / *No. KP Baru* – –

Old NRIC/BC/Passport No. / *No. KP Lama/Sijil Kelahiran/Paspot*

Name of Life Assured / *Nama Hayat yang Diasuranskan* _____

Issued by: Date:

The above named is insured with GREAT EASTERN LIFE ASSURANCE (MALAYSIA) 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, we would be obliged if you would complete this confidential report.
(IF THERE IS A CHARGE FOR COMPLETION OF THIS FORM IT IS THE RESPONSIBILITY OF THE CLAIMANT)

Please tick (/) the Critical Illness the Life Assured claiming for:

- ☐ Heart Attack
- ☐ Coronary Artery By-Pass Surgery
- ☐ Other Serious Coronary Artery Disease
  (No surgery or angioplasty / invasive treatment done)

(N.B. For the above claims to be validated, kindly submit results / copies of any investigations performed e.g. resting / serial ECG tracings, exercise stress tests, cardiac enzyme assays, coronary / cardiac angiography studies and cardiac isotope imaging)

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

   Since what date? Date _____

2. Please give the full and exact details of the diagnosis.

   (i) Please describe **this particular** episode :-

   a. Nature of episode:

   b. Date:

   c. Duration of acute symptoms:

   (ii) a. When was the illness **first diagnosed**? (If diagnosis was made prior to this particular episode.)

   b. Diagnosis was first made by: (Please state the relevant investigation / procedure upon diagnosis was made and the doctor and hospital address concerned).

3. Date the Life Assured **first consulted** you for this illness:

   a. When was the Life Assured first aware of his/her illness?

   b. What were the symptoms presented?

   c. How long had the symptoms presented prior to this episode?

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
(A member of Great Eastern Holdings Limited)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline (603) 4259 8333 Agent Service Careline (603) 4259 8111 Fax (603) 4259 8198
E-mail wecare@lifeisgreat.com.my Website www.lifeisgreat.com.my

4. Is there anything in the Life Assured's prior medical history that would have contributed to him suffering this condition?

   a. Related symptoms e.g. angina, breathlessness, palpitations etc.

   b. Related conditions e.g. hypertension, diabetes, hyperlipidaemia, other vascular disease etc.

   c. Please give details of his habits in relation to smoking and drinking.

5. If By-pass Surgery was performed: -

   a. Date of surgery:

      Please state the number and sites of grafts inserted:

   b. Who performed the procedure? (Please name the doctor concerned and his hospital address).

   c. Date of the Life Assured's return to normal daily activities:

6. Did the Life Assured consult other doctors for this condition or his symptoms **before** he consulted you? If yes, please give name(s) and address(es) of the doctor(s) whom he consulted.

Name, Address and Official Stamp

Signature _____

Date _____