CONFIDENTIAL MEDICAL CERTIFICATE (LIVING ASSURANCE)

Great Eastern

Policy No. / *No. Polisi* | Policy No. / *No. Polisi* | Policy No. / *No. Polisi* | Policy No. / *No. Polisi* | Policy No. / *No. Polisi*

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 connection with **STROKE** 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)

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

   Since what date? Date _____

2. (i) Please state the exact diagnosis: _____

   (ii) Date when illness was FIRST diagnosed: _____

   (iii) Diagnosis was first made by: _____

   (iv) Please provide details of the history of symptoms: _____

   (v) How long had symptoms been present? _____

   (vi) Date when Life Assured first became aware of the illness: _____

   (vii) Date when Life Assured first consulted you for this illness: _____

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

3. (i) Please describe the initial episode :-

   a) Nature of episode:

   b) Date: _____

   c) Duration of acute symptoms:

   d) Date of return to normal duties and / or the Life Assured's present limitations - physical and mental:

   (ii) Please comment on any neurological sequelae persisting six (6) weeks after the date of FIRST diagnosis made 2 (ii).

   Are these sequelae permanent?

   (iii) Please provide the full address of any hospitals to which the Life Assured has been referred together with the names of the consultants attended.

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4. (i) Has the Life Assured previously suffered from the condition described above or any related illness? E.g: transient ischaemic attack, reversible ischaemic neurological deficit, etc. If 'yes', please give dates of consultation and the resulting diagnosis.

(ii) Is there anything in the Life Assured's personal medical history and family history which would have increased the risk of a stroke? Eg: hypertension, diabetes, other vascular disease and relevant heart disorders, etc.

(iii) Please give details of the Life Assured's past and present smoking habits.

5. Please supply details of radiological, CT scan or MRI and laboratory evidence as well as any other tests. (We would be grateful for copies of any other relevant hospital reports that are available. This would help us to process the insurance claim promptly.)

6. If there is any further information, which, in your opinion, will assist our Medical Referee in assessing this claim, please furnish such information below:

Name, address and Official Stamp

Signature

Date