Issued by:
Date :

CONFIDENTIAL MEDICAL CERTIFICATE (LIVING ASSURANCE)

Note: This form is to be completed by the medical attendant at the Assured's expense

Name of Life Assured ……

NRIC No…….. Policy No……

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 his/her illness 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.

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

   If 'yes', since what date? Date……..

2. a. Date when Life Assured first consulted you for this illness:……

   b. Symptoms present:

   c. How long had symptoms been present?

   d. Please describe the full and exact condition, cause and diagnosis

   e. Date when illness was FIRST diagnosed:…….

   f. The diagnosis was made by:……..

   g. Date when Life Assured first became aware of the illness:……

3. Were there any tests performed that confirmed the diagnosis? Please advise the results and attach copies of the reports and/or any other investigations (ECG, stage, biopsy, histological studies etc)

4. a. What type of surgery has been performed……

   Date of Surgery……..

   b. In which hospital was the surgery performed?

   c. Date of Admission……Date of Discharge……

d. Who performed the surgery? (Please state name and address)

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5. a. Has the Life Assured previously suffered from the same or any related illness?
☐ **YES** ☐ **NO**

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

b. Is there anything in the Life Assured's personal medical history and family history which would have increased the risk of this disease?

c. Please give details of the Life Assured's habits in relation to cigarette smoking.

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

b. Please provide name(s) and address(es) of any hospital or clinic to which the Life Assured was referred together with the name(s) of the consultant(s) attended.

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7. Have you completed any reports regarding this illness for anyone else, including other insurance companies? If 'yes', please provide details.

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

Date:……

Signature……

Name, address and Official stamp

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