

Issued by:  
Date :

**CONFIDENTIAL MEDICAL CERTIFICATE  
(LIVING ASSURANCE)**

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 with **LOSS OF SPEECH** 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:-

**15. 'Loss Of Speech' : Total and irrecoverable loss of the ability to speak which must be established for a continuous period of twelve (12) months. This condition shall be confirmed by a consultant neurologist.**

- 
1. Are you the Life Assured's usual medical attendant?  YES  NO
- Since what date? Date .....
- 
2. (i) Date when you were first consulted for the injury / disease / condition causing Loss of Speech: .....
- (ii) Symptoms presented at that time Date first appeared
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 
3. (i) Please provide full and exact details of the injury / disease / condition causing Loss of Speech, and the diagnosis.
- (ii) Date when the diagnosis of "loss of speech" as defined above was first made: .....
- (iii) Diagnosis was first made by (name of doctor): .....
- (iv) Date when Life Assured first became aware of such disease /condition: .....
- 
4. (i) Were there any associated neurological or psychological complications including hysterical aphonia?

- (ii) Is the Life Assured undergoing any speech therapy sessions and if so, please detail frequency and duration.
- (iii) Has there been any improvement in the Life Assured's speech since onset of the condition?
- (iv) What investigations or tests have been performed to verify the diagnosis of irrecoverable loss of speech?

**Please attach copies of all relevant hospital reports that are available. (This would help us to process the insurance claim promptly.)**

- 
5. (i) Has the Life Assured previously suffered from the condition specified above or any related illness? If 'yes', please give dates of consultations and the resulting diagnosis.
- (ii) Did the Life Assured consult other doctors for this injury / disease / condition or related illness **before** he consulted you? If 'yes', please give name(s) and address(es) of the doctor (s) whom he consulted.

- 
6. (i) Is there anything in the Life Assured's habits or personal medical history which would have increased the risk of loss of speech?
- (ii) Please provide names and addresses of any hospital or clinic to which the Life Assured was referred together with the names of the consultants attended.

---

7. In your opinion, does the episode suffered by the Life Assured fulfil the definition of Loss of Speech stated below?

15. 'Loss Of Speech'	:	Total and irrecoverable loss of the ability to speak which must be established for a continuous period of twelve (12) months. This condition shall be confirmed by a consultant neurologist.
<input type="checkbox"/> YES		<input type="checkbox"/> NO

---

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

.....  
 .....