

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 **MOTOR NEURONE DISEASE** 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:-

20. Motor Neurone Disease : Motor neurone disease of unknown aetiology is characterised by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones; these include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis. Claims shall only be admitted if the condition is confirmed by a consultant neurologist as progressive and resulting in irreversible damage to the nervous system.

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 Motor Neurone Disease:

(ii) <u>Symptoms presented at that time</u>	<u>Date first appeared</u>
_____	_____
_____	_____
_____	_____

(iii) Please provide full and exact details of the diagnosis, including date of diagnosis.

(iv) Please provide details of any investigations performed.

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

(This would help us to process the insurance claim promptly)

(v) Diagnosis was first made by (name of doctor):

(vi) Date when Life Assured first became aware of the illness / condition:.....

3. (i) Please provide details, including dates, of the extent of the neurological deficit.

(ii) Please give details of current treatment.

4. (i) Has the Life Assured previously suffered from the condition specified above or any possible related illnesses? We are particularly interested in any consultations, however minor in nature, concerning neurological symptoms or complaints. **YES** **NO**

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

5. 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.

6. 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. Do you unequivocally confirm that the Life Assured is suffering from Motor Neurone Disease?
 YES **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

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Qualifications

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