

**CONFIDENTIAL MEDICAL CERTIFICATE
(LIVING ASSURANCE - CANCER)**



Policy No. <input style="width:100%;" type="text"/>	New NRIC No. <input style="width:100%;" type="text"/>	- <input style="width:100%;" type="text"/>
Policy No. <input style="width:100%;" type="text"/>	Old NRIC/Birth Certificate/ Passport No. <input style="width:100%;" type="text"/>	
Policy No. <input style="width:100%;" type="text"/>	Name of Life Assured _____	
Policy No. <input style="width:100%;" type="text"/>		

The above name 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 **CANCER** and to enable us to assess the claim, kindly complete this confidential report.
(For any medical report fee incurred in completing this form, it will be borne by claimant)

Please attach certified true copies of all the relevant laboratory evidences or tests available.

<input type="checkbox"/> Histopathology examination (HPE) / Biopsy report	<input type="checkbox"/> CT Scan / MRI / Radiological reports
<input type="checkbox"/> Bone marrow aspiration / trephine biopsy report	<input type="checkbox"/> Blood and laboratory test results
<input type="checkbox"/> Surgical Report	<input type="checkbox"/> Other reports. Please give details: _____

1. Are you the Life Assured's usual medical attendant? Yes No
If "YES", since what date? / / (dd/mm/yyyy)

2. Has the Life Assured previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?
 Yes No
If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name and Address of Clinic / Hospital

3. Date when Life Assured FIRST consulted you for Cancer. / / (dd/mm/yyyy)

4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Life Assured had been experiencing these symptoms.

Symptoms	Date symptoms first started (dd/mm/yyyy)
(a)	
(b)	

What is the source of this information?
 Patient
 Referring doctor
 Name of doctor and hospital / clinic: _____
 Others, please specify: _____

5. Diagnosis

(i) Please describe the full and exact diagnosis.	(i) _____
(ii) Date when Cancer was FIRST diagnosed.	(ii) <input style="width:100px;" type="text"/> / <input style="width:100px;" type="text"/> / <input style="width:100px;" type="text"/> (dd/mm/yyyy)
(iii) Diagnosis was FIRST made by (name of doctor and hospital)	(iii) _____
(iv) Date when Life Assured FIRST became aware of the illness.	(iv) <input style="width:100px;" type="text"/> / <input style="width:100px;" type="text"/> / <input style="width:100px;" type="text"/> (dd/mm/yyyy)

6. (i) What was the site or organ involved? (i) _____
 (ii) What was the precise histology of the tumour? (ii) _____

<p>(iii) What was the staging of the tumour? Please provide full details using appropriate staging classification (e.g. TNM, FIGO, Ann Arbor, Duke's etc.)</p> <p>(iv) It is classified as:</p> <p>(v) The disease was: You may tick (✓) more than one.</p>	<p>(iii) _____</p> <p>_____</p> <p><input type="checkbox"/> borderline malignancy <input type="checkbox"/> carcinoma in-situ</p> <p><input type="checkbox"/> having low malignant potential <input type="checkbox"/> non-invasive</p> <p><input type="checkbox"/> having high malignant potential <input type="checkbox"/> invasive</p> <p><input type="checkbox"/> pre-malignant</p> <p><input type="checkbox"/> invasive to adjacent tissues <input type="checkbox"/> completely localized</p> <p><input type="checkbox"/> involved regional lymph nodes</p> <p><input type="checkbox"/> distant metastatic. If so, please give details</p> <p>_____</p>
<p>7. Type of investigations / tests done to confirm the diagnosis.</p>	<p><input type="checkbox"/> Biopsy / Histopathology <input type="checkbox"/> Tumour marker test</p> <p><input type="checkbox"/> Bone marrow aspiration / Trephine</p> <p><input type="checkbox"/> Others, please specify: _____</p>

8. Please provide full details of all treatments provided.

Treatment	Type and details	Treatment Commencement Date
Surgery		
Radiotherapy		
Chemotherapy		
Others, please specify:		

9. Please provide the full address of any hospitals to which the Life Assured has been referred together with the names of the consultant attended.

Hospital	Address	Name of consultant	Date of consultation

10. Is the Cancer associated with HIV or AIDS? Yes No

If "YES", please state the date HIV was first diagnosed / detected.

/ / (dd/mm/yyyy)

11. Has the Life Assured previously suffered from or detected to have raised tumour marker, abnormal PAP smear, benign tumour, pre-malignant condition, cancer, hypertension, diabetes, hyperlipidaemia, cardiovascular diseases or any other significant illnesses?

Yes No

If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Name of Doctor	Name and Address of Clinic / Hospital

12. Please provide us with any other information that will enable the Company to assess this claim.

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, certify that I have examined the above Life Assured and that I have answered the above questions are true and to the best of my knowledge and belief.

<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p>Signature and Official Stamp</p>	<p>Name: _____</p> <p>Address: _____</p> <p>Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)</p>
--	---