

**CONFIDENTIAL MEDICAL CERTIFICATE  
(LIVING ASSURANCE - OTHER ILLNESSES)**



Policy No.	<input type="text"/>	New NRIC No.	<input type="text"/> - <input type="text"/> - <input type="text"/>
Policy No.	<input type="text"/>	Old NRIC/Birth Certificate/ Passport No.	<input type="text"/>
Policy No.	<input type="text"/>	Name of Life Assured	_____
Policy No.	<input 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 within the coverage of a Critical Illness benefit 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)

Claims Condition Suffered (Please tick ( / ) where applicable)

<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Fulminant Hepatitis	<input type="checkbox"/> Major Organ Transplant
<input type="checkbox"/> Total Permanent Blindness	<input type="checkbox"/> End Stage Liver Disease	<input type="checkbox"/> Terminal Illness
<input type="checkbox"/> Total Permanent Deafness	<input type="checkbox"/> End Stage Lung Disease	<input type="checkbox"/> Aplastic Anaemia
<input type="checkbox"/> Loss of Speech	<input type="checkbox"/> HIV Infection From Blood Transfusion	<input type="checkbox"/> Full Blown AIDS
<input type="checkbox"/> Major Burns	<input type="checkbox"/> AIDS Cover of Medical Staffs	<input type="checkbox"/> Loss of Independent Existence
<input type="checkbox"/> Systemic Lupus Erythematosus (SLE) with Lupus Nephritis		

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 the illness.  /  /  (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 presented (dd/mm/yyyy)
(a)	
(b)	

What is the source of this information?  
 Life Assured  
 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 the illness was FIRST diagnosed.	(ii) <input type="text"/> / <input type="text"/> / <input 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 type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
(v) What is the underlying cause of the illness as per diagnosis above?	(v) _____

(vi) When was the underlying cause FIRST diagnosed?	(vi) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy) Name of treating doctor and clinic / hospital. <hr/> <hr/> <hr/>
6. Type of investigations / tests done to confirm the diagnosis.	<hr/> <hr/> <hr/>
7. Please give details of completed, planned or current treatment for the illness stated above.	<hr/> <hr/> <hr/>
8. What is the current condition of the Life Assured and what is the prognosis?	<hr/> <hr/> <hr/>
9. Please provide us with any other information that will enable the Company to assess this claim. <hr/> <hr/> <hr/>	

**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.

Signature and Official Stamp

Name: \_\_\_\_\_

Address:

Date:  /  /  (dd/mm/yyyy)