

TOTAL & PERMANENT DISABILITY CLAIM DOCTOR'S STATEMENT



| | | | |
|-----------------|----------------------|---|--|
| Certificate No. | <input type="text"/> | New NRIC No. | <input type="text"/> - <input type="text"/> - <input type="text"/> |
| Certificate No. | <input type="text"/> | Old NRIC/Birth Certificate/ Passport No. | <input type="text"/> |
| Certificate No. | <input type="text"/> | | |
| Certificate No. | <input type="text"/> | Name of Person Covered | <input type="text"/> |

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted in within the coverage of a Total and Permanent Disability 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)

| | |
|--|---|
| 1. Are you the Person Covered's usual medical attendant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "YES", since what date? | <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) |

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|--|
| 2. Has the Person Covered previously suffered from or been detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder, pre-malignant condition, cancer or any other significant illnesses? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "YES", please provide the following: |

| Medical Condition | Date of Diagnosis | Medication / Treatment | Name of Treating Doctor | Name and Address of Clinic / Hospital |
|----------------------|----------------------|------------------------|-------------------------|---------------------------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | |
|--|---|
| 3. (i) Date when Person Covered FIRST consulted you for the illness. | (i) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) |
| (ii) Date(s) of subsequent consultation(s) / follow up(s) | (ii) <input type="text"/> |

| 4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Person Covered had been experiencing these symptoms. | | | | | | |
|--|--|--|-----|----------------------|-----|----------------------|
| <table border="1"> <thead> <tr> <th>Symptoms</th> <th>Date symptoms first presented (dd/mm/yyyy)</th> </tr> </thead> <tbody> <tr> <td>(a)</td> <td><input type="text"/></td> </tr> <tr> <td>(b)</td> <td><input type="text"/></td> </tr> </tbody> </table> | Symptoms | Date symptoms first presented (dd/mm/yyyy) | (a) | <input type="text"/> | (b) | <input type="text"/> |
| Symptoms | Date symptoms first presented (dd/mm/yyyy) | | | | | |
| (a) | <input type="text"/> | | | | | |
| (b) | <input type="text"/> | | | | | |

What is the source of this information?

| |
|---|
| <input type="checkbox"/> Person Covered |
| <input type="checkbox"/> Referring doctor |
| Name of doctor and hospital / clinic: <input type="text"/> |
| <input type="checkbox"/> Others, please specify: <input type="text"/> |

| | |
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| 5. Diagnosis | |
| (i) Please describe the full and exact diagnosis. | (i) <input type="text"/> |
| (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) <input type="text"/> |
| (iv) Date when Person Covered FIRST became aware of the illness. | (iv) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) |
| (v) Date when diagnosis was first made to the Person Covered. | (v) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) |
| (vi) What was the exact information conveyed to the Person Covered? | (vi) <input type="text"/> |
| (vii) What is the underlying cause of the illness for the diagnosis above? | (vii) <input type="text"/> |

CLM-TPDDS-V03-042015-TAKAFUL

Great Eastern Takaful Berhad (916257-H)

Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Telephone: +603 4259 8338 Fax: +603 4259 8808 Customer Service Careline: 1 300 13 8338
E-mail: i-greatcare@i-great.com.my Website: www.i-great.com

| 6. (i) Type of investigations / tests done to confirm the diagnosis (ii) Type of treatments given and his / her response to the treatments. | (i) _____ _____ (ii) _____ _____ | | | | | | | | | | | | |
|---|--|----------------------------|-------------------------------------|----------------------------|--------|--|--|----------|--|--|--|----|----|
| 7. (i) Person Covered's occupation before disability (ii) Nature of duties of the occupation in 7 (i) (iii) How does the Person Covered's disability prevent him / her from performing the above listed duties of his / her occupation? | (i) _____ (ii) _____ _____ (iii) _____ _____ | | | | | | | | | | | | |
| 8. Did the Person Covered consult other doctors for this condition or its symptoms BEFORE he / she consulted you? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please provide the following: | | | | | | | | | | | | | |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 33%;">Name of Doctor</th> <th style="width: 33%;">Name of Clinic/Hospital and Address</th> <th style="width: 33%;">Date of First Consultation</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> | | Name of Doctor | Name of Clinic/Hospital and Address | Date of First Consultation | | | | | | | | | |
| Name of Doctor | Name of Clinic/Hospital and Address | Date of First Consultation | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Question 9 to be completed if disability caused by an accident | | | | | | | | | | | | | |
| 9. (i) Is the condition a result of an accident? (ii) Describe in detail how the accident happened (iii) Was the Person Covered under the influence of alcohol / drug at the time of accident? (iv) Is the condition self-inflicted? | (i) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please state the date of accident <div style="border: 1px solid black; display: inline-block; padding: 2px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> (dd/mm/yyyy) (ii) _____ _____ (iii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please state the blood alcohol content/drug type and quantity consumed. _____ (iv) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please provide full details _____ | | | | | | | | | | | | |
| Please complete the Question 11 to 20 based on your latest detailed examination at the date in Question 10. | | | | | | | | | | | | | |
| 10. Last examination / consultation date | <div style="border: 1px solid black; display: inline-block; padding: 2px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> (dd/mm/yyyy) | | | | | | | | | | | | |
| 11. Please describe fully the nature of the Person Covered's disabilities. | _____ _____ | | | | | | | | | | | | |
| 12. Vision (Visual Acuity) | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 70%;"></th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> </tr> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on Metric Acuity</td> <td> </td> <td> </td> </tr> </table> Remarks: _____ | | Right | Left | Normal | | | Impaired | | | Scores based on Metric Acuity | | |
| | Right | Left | | | | | | | | | | | |
| Normal | | | | | | | | | | | | | |
| Impaired | | | | | | | | | | | | | |
| Scores based on Metric Acuity | | | | | | | | | | | | | |
| 13. Hearing | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 70%;"></th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> </tr> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on speech reception threshold</td> <td style="text-align: center;">dB</td> <td style="text-align: center;">dB</td> </tr> </table> <div style="text-align: right; font-size: small;">(Supported by an Audiometry results)</div> Remarks: _____ | | Right | Left | Normal | | | Impaired | | | Scores based on speech reception threshold | dB | dB |
| | Right | Left | | | | | | | | | | | |
| Normal | | | | | | | | | | | | | |
| Impaired | | | | | | | | | | | | | |
| Scores based on speech reception threshold | dB | dB | | | | | | | | | | | |
| 14. Function of speech | <input type="checkbox"/> Clear and understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Unable to speak Remarks: _____ | | | | | | | | | | | | |
| 15. Cognitive function | <input type="checkbox"/> Normal <input type="checkbox"/> Poor comprehension <input type="checkbox"/> Difficult with logic and reasoning <input type="checkbox"/> Memory loss Remarks: _____ | | | | | | | | | | | | |

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| 16. General examination findings: (i) Are there any abnormal movements or abnormal gait? (Please provide full details) (ii) Is there any muscle wasting? (Please provide full details) (iii) If there are any other significant examination findings, please provide the details. | (i) _____ _____ _____ (ii) _____ _____ _____ (iii) _____ _____ _____ |
|--|--|

17. Examination of the Limbs

(i) Please indicate the muscle power of the various joint in the table below with the maximum grade of 5.

| Upper Limbs | Right | Left |
|-------------|-------|------|
| Shoulder | | |
| Elbow | | |
| Wrist | | |
| Grip | | |
| Lower Limbs | Right | Left |
| Hip | | |
| Knee | | |
| Ankle | | |

Remarks: _____

(ii) Please indicate the Range of Movement of the various joint in the table below.

| Upper Limbs | Right | Left |
|-------------|-------|------|
| Shoulder | | |
| Elbow | | |
| Wrist | | |
| Finger(s) | | |
| Lower Limbs | Right | Left |
| Hip | | |
| Knee | | |
| Ankle | | |

Remarks: _____

18. Assessment of Activities of Daily Living

| Activities of Daily Living | Not Limited | Limited | Incapable |
|---|-------------|---------|-----------|
| Transfer (Getting in & out of a chair without physical assistance) | | | |
| Mobility (Ability to move from room to room without physical assistance) | | | |
| Continence (Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene) | | | |
| Dressing (Putting on & taking off all necessary items of clothing without assistance of another person) | | | |
| Bathing / Washing (Ability to wash in the bath or shower, including getting in & out of bath or shower or wash by any other means without assistance of another person) | | | |
| Eating (All task of getting food into the body without assistance of another person) | | | |

