هوڠ ليوڠ م. س. أ. ج. تكافل

HongLeong MSIG Takaful

Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

This report is to be completed by the registered medical practitioner at the own expense of Participant / Claimant.

In order for a claim under this Takaful Certificate condition to be paid, the following definition must be satisfied:

STROKE

Defined as cerebrovascular accident or incident producing neurological sequelae of a permanent nature, having lasted not less than six (6) months. Infarction of brain tissue, hemorrhage and embolization from an extra-cranial source are included. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist.

Specifically excluded are cerebral symptoms due to transient ischaemic attacks, any reversible ischaemic neurological deficit, vertebrobasilar ischaemia, cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve or vestibular functions.

1. a) Name of Participant. b) I/C No. c) Date of Birth. d) Present Occupation. (If more than one, please state all) e) Takaful Certificate No.	a) b) Old: New: c) DD_____ MM_____ YY_____ d) e)
2. Please describe the exact details of your patient's present condition.	
3. a) When did your patient first consult you for this condition ? b) Symptoms presented at that time. c) Date of symptoms first appeared.	a) DD_____ MM_____ YY_____ b) c) DD_____ MM_____ YY_____
4. When did your patient first become aware of this condition?	DD_____ MM_____ YY_____
5. Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If so, please give details?	

	Consultation Dates	Name and Address of Doctor(s)
6. a) Was your patient referred to you? If so, please give name and address of doctor concerned.	a)	
b) Name and address of doctor(s) who attended to your patient prior to seeing you.	b)	
c) Name and address of doctor(s) concurrently treating your patient with you for this condition.	c)	
d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	d)	
7. a) Please state date of diagnosis.	a)	DD_____ MM_____ YY_____
b) Name and address of doctor who established the diagnosis.	b)	
c) Was your patient informed of the diagnosis? If so, when and by whom?	c)	DD_____ MM_____ YY_____
8. Have any other investigative tests procedures been performed? If so, please give details.		
9. Please give details of your patient's smoking habits, both past and present.		
a) Does the patient smoke?	a)	
i) If "Yes", how many sticks does the patient smoke in a day?	i)	
ii) What is the exact duration?	ii)	
b) If "No", is the patient a non-smoker?	b)	
c) If he was a smoker in the past, then when did the patient stop smoking?	c)	

10. Has the patient ever been diagnosed / suffered from any of the following: *If yes, please provide the exact date of diagnosis*	
a) Hypertension.	a) DD_____ MM_____ YY_____
b) Diabetes Mellitus.	b) DD_____ MM_____ YY_____
c) Cardiovascular Disease.	c) DD_____ MM_____ YY_____
d) Other illness(es) / injuries.	d) DD_____ MM_____ YY_____
11. Please give any other information which you feel would be helpful in the assessment of your patient's claim.	

We would be most grateful if you could send copies of any specialist or hospital reports, together with any tests, readings, or similar evidence to support the validity of your patient's claim.

Official Stamp:

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Date: _____

For Office Use Only

Checked and Verified By: _____ Date: _____ Branch: _____
(Name of Staff)