هونغ ليونغ 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:

PARALYSIS / PARAPLEGIA

The complete and permanent loss of use of both arms or both legs, or one arm and one leg, through paralysis caused by illness or injury persisting for at least six (6) months from date of trauma or illness.

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) d) e)
2. Which limbs are affected?	
3. Please describe the exact details of your patient's present condition.	
4. a) When did your patient first consult you for this condition? b) Symptoms presented at that time. c) Date symptoms first appeared.	a) b) c)
5. When did your patient first become aware of this condition?	

6. 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.	
7. Are you aware of any members of your patient's close family who have suffered from this or any similar conditions?	
8. a) Was your patient referred to you? If so, please give name and address of doctor concerned.	Consultation Dates Name and Address of Doctor(s) 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)
9. Please complete the section below relating to your patient's condition.	
a) Details of exact loss of functions.	a)
b) Did your patient have any residual use, no matter how minor, of his affected limbs?	b)

Question	Answer
c) Was the condition permanent without any likelihood of recovery?	c)
d) Was there any possibility of a surgical operation or any other forms of curative treatment?	d)
10. a) Please state date of diagnosis.	a)
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)
11. Have any other investigative tests or procedures been performed? If so, please give details.	
12. 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)

13. Has the patient ever been diagnosed / suffered from any of the following:	Diagnosis	Date of Diagnosis / Onset	Name and Address of Doctor(s) Consulted	Dates of Treatment Consulted
a) Hypertension.	a)			
b) Diabetes Mellitus.	b)			
c) Cardiovascular Disease.	c)			
d) Kidney Disease.	d)			
e) Cancer or Tumour.	e)			
f) Similar / same disability previously.	f)			
g) Excessive narcotic or alcohol consumption.	g)			
h) Any habit forming drugs.	h)			
i) Have been treated for alcoholism or narcotic or drug abuse.	i)			
j) Other illness(es) / injuries.	j)			
If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.				
14. 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)