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 policy condition to be paid, the following definition must be satisfied:

ACQUIRED IMMUNO-DEFICIENCY SYNDROME (AIDS)

a) AIDS Due to Blood Transfusion

The Participant being infected by HIV virus or AIDS provided that:

- The infection is due to blood transfusion received in Malaysia or Singapore after the commencement of the Takaful Certificate.
- The Participant is not a hemophiliac; and
- The Participant is not a member of any high-risk groups such as but not limited to homosexuals, intravenous drug users or sex workers.

Notification & proof of incident will be required via a statement from a statutory Health Authority that the infection is medically acquired.

b) Full Blown AIDS

The clinical manifestation of AIDS must be supported by the results of a positive HIV (Human Immuno-deficiency Virus) antibody test and a confirmatory Western Blot test. In addition, the Participant must have a CD4 cell count of less than two hundred (200) and one (1) or more of the following criteria are met:

- Weight loss of more than ten percent (10%) of body weight over a period of six (6) months or less (wasting syndrome);
- Kaposi Sarcoma;
- Pneumocystic Carinii Pneumonia;
- Progressive multifocal leukoencephalopathy;
- Active Tuberculosis;
- Less than one-thousand (1000) lymphocytes;
- Malignant Lymphoma.

1. a) Name of Participant.	a)
b) I/C No.	b) Old: New:
c) Date of Birth.	c)
d) Present Occupation. (If more than one, please state all)	d)
e) Takaful Certificate No.	e)

2. Please describe the exact details of your patient's present condition.	
3. a) Are you the usual medical attendant of the above named?	a)
b) Date of first consultation at your medical practice?	b)
c) Date of last consultation at your medical practice?	c)
d) Date of first consultation for the positive HIV status?	d)
e) Date of onset of signs and symptoms of HIV infection.	e)
4. Kindly provide dates of all VDRL or HIV antibody test performed and their results.	Date / Type of Blood and Result / Remarks

5. Did the above named belong to any of the following groups?	Yes	No	Others: Please Specify
a) Homosexual or bisexual behavior group.	a) ☐	☐	
b) Haemophiliacs.	b) ☐	☐	
c) Intravenous drug user.	c) ☐	☐	
d) The spouse or the sexual partner of the above groups.	d) ☐	☐	

6. a) Please provide reasons why a blood transfusion was given to this patient.	a)
b) Please provide date of first consultation and details of the history of this HIV infection.	b)
c) Name and address of the hospital where the blood transfusion was carried out.	c)
d) Was the blood that was transfused screened for antibodies to the HIV?	d)
e) Date the blood transfusion was given.	e)
f) Date the patient was first diagnosed to the HIV positive.	f)
g) Was your patient informed of the diagnosis? If so, when and by whom?	g)
h) Date the blood transfusion was given.	h)

7. HIV Blood test results for HIV antibodies.	Date	Elisa Test Result	Western bolt Test Result
HIV Status: a) Pre blood transfusion.	a)		
b) Post blood transfusion.	b)		

8. When did your patient first aware of this condition?	
9. a) Was your patient referred to you? If so, please give name and address of doctor concerned. b) Name and address of doctor(s) who attended to your patient prior to seeing you. c) Name and address of doctor(s) concurrently treating your patient with you for this condition. d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	a) b) c) d)
10. a) Please state date of diagnosis. b) Name and address of doctor who established the diagnosis. c) Was your patient informed of the diagnosis? If so, when and by whom?	a) b) c)
11. Have any other investigative test 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? i) If "Yes", how many sticks does the patient smoke in a day? ii) What is the exact duration? b) If "No", is the patient a non-smoker? c) If he was a smoker in the past, then when did the patient stop smoking?	a) i) ii) b) c)			
13. Has the patient ever been diagnoses / suffered from any of the following: a) Hypertension. b) Diabetes Mellitus. c) Cardiovascular Disease. d) Other illness(es) / injuries. If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	Diagnosis a) b) c) d)	Date of Diagnosis / Onset	Name and Address of Doctor(s) Consulted	Dates of Treatment Consulted
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: _____

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