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:

KIDNEY FAILURE

End stage renal failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated or renal transplantation is carried out.

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. 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.	
6. 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)
7. Please complete the section below relating to your patient's condition. a) Please confirm the diagnosis of end stage renal failure with chronic irreversible failure of **both** kidneys to function. b) Is regular renal dialysis being performed? If so, please provide: i) Place it was performed. ii) Date of patient's first dialysis. iii) How frequent is patient on dialysis? c) Has a renal transplant been performed? i) If so, state the date of the transplant	a) b) i) ii) DD_____ MM_____ YY_____ iii) c) i) DD_____ MM_____ YY_____

ii) If no, is it likely to be considered in the future?	ii)
8. 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) DD_____ MM_____ YY_____ b) c)
9. Have any other investigative tests or procedures been performed? If so, please give details.	
10. 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)
11. Has the patient ever been diagnoses / suffered from any of the following? *If yes, please state the date of diagnosis* a) Hypertension. b) Diabetes Mellitus. c) Cardiovascular Disease. d) Other Kidney Disease / Disorder.	a) DD_____ MM_____ YY_____ b) DD_____ MM_____ YY_____ c) DD_____ MM_____ YY_____ d) DD_____ MM_____ YY_____

e) Systemic Disease such as SLE.	e) DD_____ MM_____ YY_____
f) Other Illness(es) / Injuries. If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	f) DD_____ MM_____ YY_____
12. 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)