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:

CARDIOMYOPATHY

The unequivocal diagnosis by a Consultant Cardiologist of cardiomyopathy causing impaired ventricular function suspected by ECG abnormalities and confirmed by cardiac echo of variable etiology and resulting in permanent physical impairments to the degree of at least Class III of the New York Association Classification of cardiac impairment.

Class: III = Marked limitation – Such patients are comfortable at rest but performing less than ordinary activity will lead to symptoms of Congestive Cardiac Failure.

Class IV = Inability to carry out any activity without discomfort. Symptoms of Congestive Cardiac Failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

Cardiomyopathy directly related to alcohol misuse is excluded.

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) b) c)

4. When did your patient first become aware of this condition?	
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 Cardiomyopathy. b) Please give full details of all investigations performed in relation to this conditions and their results. c) Please advise the name and address of the consultant Cardiologist who had confirmed the diagnosis of Cardiomyopathy.	a) b) c)

d) Please confirm if your patient falls within either Class III or IV of the New York Association Classification of cardiac impairment. e) Please provide details of your patient's alcohol consumption.	d) e)
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) 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 diagnosis / 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) Cardiovascular Disease.	b)			
c) Diabetes Mellitus.	c)			
d) Excessive narcotic or alcohol consumption.	d)			
e) Any habit forming drugs.	e)			
f) Has been treated for alcoholism or narcotic or drug abuse.	f)			
g) Other illness(es) / Injuries.	g)			
If so, please provide the diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.				
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)