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:

TERMINAL ILLNESS

The conclusive diagnosis of a condition that is expected to result in death of the Person Covered within twelve (12) months. The Person Covered must no longer be receiving active treatment other than that for pain relief. The diagnosis must be supported by written confirmation from the appropriate specialist and confirmed by the Takaful Operator's appointed doctor.

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?	

	Consultation Dates / Name and Address of Doctor(s)
5. 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)
6. Please complete the section below relating to your patient's condition. a) What is the diagnosis? Please describe the full and exact diagnosis of the condition causing patient to be terminally ill.	a)
b) Please state date of diagnosis.	b)
c) Name and address of doctor who establish the diagnosis.	c)
d) Was your patient/ patient's next of kin was informed that the illness was terminal? If so, when and by whom?	d)
7. a) How long is the life expectancy of the patient?	a) _____ months
b) Is the patient's condition incurable and cannot be adequately treated to recover?	b) ☐ Yes ☐ No
c) If **Yes**, please provide your basis	c)
d) What treatment is the patient currently receiving? Please tick which is applicable.	d) ☐ Transplant Date of transplant: ____ / ____ / _____ (dd/mm/yyyy) ☐ Chemotherapy/Radiotherapy ☐ Physiotherapy ☐ Palliative care

	☐ Medication (s) Please list down all medication prescribed to the patient now. _____ _____ _____ _____
8. Have any other investigative tests 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 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) Other illness(es) / injuries.	d)			
If so, please provide the diagnosis, date of diagnosis / onset, names & addresses of all doctors consulted and dates of consultation.				
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)