TAKAFUL IKHLAS FAMILY BERHAD (593075-U)
(Formerly known as Takaful Ikhlas Berhad)
IKHLAS Point, Tower 11A, Avenue 5, Bangsar South,
No.8, Jalan Kerinchi, 59200 Kuala Lumpur.
Tel : 03 2723 9999 Fax: 03 2723 9998
Website : www.takaful-ikhlas.com.my

STROKE

(to be completed by doctor)

Patient Name : _____

I/C No : _____

Certificate No : _____

The above named has a coverage with Takaful Ikhlas Family Berhad against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with a Stroke and, to enable us to assess the claim, we would appreciate it if you could complete this confidential report and return it direct to us at the following address:-

TAKAFUL IKHLAS FAMILY BERHAD (593075-U)
(Formerly known as Takaful Ikhlas Berhad)
Benefit Payable Department
IKHLAS Point, Tower 11A, Avenue 5
Bangsar South, No.8, Jalan Kerinchi
59200 Kuala Lumpur.

In order for the claim to be valid the following definition must be fulfilled.

STROKE – resulting in permanent neurological deficit with persisting clinical symptoms

Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolization from an extra cranial source resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist. A minimum Assessment Period of three (3) months applies.
For the above definition, the following are not covered:
(i) Transient ischemic attacks
(ii) Cerebral symptoms due to migraine
(iii) Traumatic injury to brain tissue or blood vessels
(iv) Vascular disease affecting the eye or optic nerve or vestibular functions

1. General

i) Are you the participant's usual medical attendant? If yes, over what period do your records extent?

_____
_____

ii) When were you first consulted for this disease, at that time, how long had symptoms been present?

_____
_____

iii) Has the participant previously suffered from the condition specified above or any related illness? e.g. hypertension, transient ischemic attack, angina or other vascular disease. If yes, please give dates of consultation and the resulting diagnosis.

_____
_____

iv) On which date did the participant first become aware of the disease?

_____

v) Is there anything in the participant's family history which would have increased the risk of stroke?.

_____
_____

vi) Please give details of the participant's habits in relation to cigarette smoking.

_____
_____

2. Details of the participant's illness:-

i) Please provide full and exact details of the diagnosis.

_____
_____
_____

ii) Please describe the initial episode:-

a) Nature of episode.

_____
_____

b) Date: _____

c) Duration of acute symptoms _____

d) Date of return to normal activities and/or the participant's present limitations- physical and mental.

_____

_____

iii) Please comment on any neurological sequelae which lasted more than 24hours and what is the date of observation?
Observation date: _____
Observation:_____
_____

iv) Is there any neurological sequelae from that attack 6 months after the stroke and what is the date of observation?
Observation date: _____
Observation: _____
_____

v) Are these sequelae permanent?

_____

vi) Has there been an infarction of brain tissue, hemorrhage of embolisation from an extra cranial source?

_____

_____

vii) What is the patient condition when he/she last visited hospital?

_____

viii) When was the latest follow-up of the patient for the above illness (dd/mm/yyyy)?

_____

ix) What was his condition during the latest follow up?

_____

_____

x) Please supply details of radiological, CT scanning or NM imaging and laboratory evidence as well as any other tests.

_____

_____

_____

We would be grateful for copies of any relevant hospital reports that are available.

4) Please provide the full address of any hospitals to which the participant has been referred together with the names of the consultants attended.

_____
_____
_____

5) Please give names and addresses of any other medical practitioner who to your knowledge attended to the participant during the past three years.

_____
_____
_____

3) If there is any further information which, in your opinion, will assist us in assessing the claim, please furnish such information below.

_____
_____
_____

Signature_____ Name _____

Clinic _____ Qualification _____

Date _____ Telephone No._____

Official stamp: