Great Eastern Life

CONFIDENTIAL MEDICAL CERTIFICATE
(LIVING ASSURANCE)

Issued by:
Date :

Name of Life Assured : .....

NRIC No : ..... **Policy No** : .....

The above named is insured with Great Eastern Life Assurance (Malaysia) Berhad against the happening of certain contingent events associated with his / her health. A claim has been submitted in connection with **BLINDNESS** and, to enable us to assess the claim, we would be obliged if you would complete this confidential report and return it direct to us in the self-addressed envelope provided.

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

1. 'Blindness' : **Total, clinically certified, irreversible loss of sight in both eyes as a result of acute sickness or accident. The blindness must be certified by an ophthalmologist's report.**

1. Are you the Life Assured's usual medical attendant ? ☐ **YES** ☐ **NO**

   Since what date ? Date .....

2. (i) Date when you were first consulted for the injury / disease / condition causing Blindness:
   Date: .....

Symptoms presented at that time	Date first appeared

3. (i) Please provide full and exact details of the injury / disease / condition causing blindness and the diagnosis.

   Please attach copies of all relevant hospital reports that are available. (This would help us to process the insurance claim promptly)

   (ii) Date when the diagnosis of 'Blindness' as defined above was first made : .....

   (iii) Diagnosis was first made by (name of doctor) : .....

   (iv) Date when Life Assured first became aware of such disease / condition : .....

4. (i) Has the Life Assured previously suffered from any eye disease or any related illness?
   If 'yes', please give dates of consultations and the resulting diagnosis.

(ii) Were there any associated systemic diseases?

(iii) Is there any residual vision in either eye? ☐ **YES** ☐ **NO**

If 'yes', please give details of the degree of vision (please express numerically where possible)

(iv) Is there any surgery available that could reinstate vision in either or both eyes? If 'yes', please state type of surgery.

(v) Please confirm whether blindness in both eyes will be of a permanent nature.

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5. (i) Is there anything in the Life Assured's habits or personal medical history which would have increased the risk of blindness?

(ii) Have any of the Life Assured's family (whether living or dead) suffered from eye disease including blindness, cataract, glaucoma or retinitis pigmentosa?

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6. (i) Did the Life Assured consult other doctors for this injury / disease / condition or related illness **before** he consulted you? If 'yes', please give name(s) and address(es) of the doctor(s) whom he consulted.

(ii) Please provide names and addresses of any hospital or clinic to which the Life Assured was referred together with the names of the consultants attended.

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7. In your opinion, does the episode suffered by the Life Assured fulfil the definition of Blindness stated below?

11. 'Blindness' :	**Total, clinically certified, irreversible loss of sight in both eyes as a result of acute sickness or accident. The blindness must be certified by an ophthalmologist's report.**

☐ **YES** ☐ **NO**

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8. If there is any further information which, in your opinion, will assist our Medical Referee in assessing this claim, please furnish such information below:

Date .....

Signature ... .

Name, address and Official Stamp

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