



# Great Eastern Life

Issued by: \_\_\_\_\_  
Date : \_\_\_\_\_

**CONFIDENTIAL MEDICAL CERTIFICATE  
(LIVING ASSURANCE)**

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 **DEAFNESS** 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:-

**13. 'Deafness' : Total, irreversible loss of hearing in both ears for all sounds as a result of acute sickness or accident. Medical evidence in form of audiometric and sound-threshold test must be provided.**

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 Deafness.  
Date: .....

Symptoms presented at that time

Date first appeared

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. (i) Please provide full and exact details of the injury / disease / condition causing deafness 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 diagnosis of 'Deafness' 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 ear disease or any related illness? If 'yes', please give dates of consultations and the resulting diagnosis.

(ii) What treatment is currently being administered?

(iii) Is there any residual hearing in either ear?  YES  NO

If 'yes' please give details of the degree of hearing.

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

(v) Please confirm whether deafness in both ears will be of a permanent nature.

5. Is there anything in the Life Assured's lifestyle or personal medical history which would have increased the risk of deafness?

6. (i) Did the Life Assured consult other doctors or 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.

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

(13). 'Deafness' : **Total, irreversible loss of hearing in both ears for all sounds as a result of acute sickness or accident. Medical evidence in form of audiometric and sound-threshold test must be provided.**

YES

NO

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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