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 **MUSCULAR DYSTROPHY** 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:-

27. 'Muscular Dystrophy'	:	**A hereditary muscular dystrophy confirmed by consultant neurologist resulting in the inability to perform without assistance three or more of the following: bathing, dressing, using the lavatory, eating, ability to move in or out of a bed or chair.**

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 Muscular Dystrophy :.....

   (ii) Symptoms presented at that time — Date first appeared

   _____ _____

   _____ _____

   _____ _____

   (iii) Please provide full and exact details of the diagnosis.

   (iv) Please provide details of any investigations performed.

   We would be grateful for copies of any relevant hospital reports that are available. (This would help us to process the insurance claim promptly)

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

   (vi) Date when condition was FIRST diagnosed:.....

   (vii) Date when Life Assured first became aware of the condition: .....

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3. (i) Please provide details, including dates, of the extent of the neurological deficit.

(ii) Please give details of current treatment.

4. (i) Has the Life Assured previously suffered from the condition specified above or any possibl related illnesses? We are particularly interested in any consultations, however minor in natu concerning neurological symptoms or complaints.

☐ **YES** ☐ **NO**

(ii) If 'yes', please give dates of consultations and the resulting diagnosis.

5. Are you aware of any blood relative suffering from a similar or related illness? If 'yes', please state relationship, nature of illness and the date the illness was first diagnosed, if known.

6. Did the Life Assured consult other doctors for this illness or its symptoms **before** he consulted you? 'yes', please give name(s) and address(es) of the doctor(s) whom he consulted.

7. 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.

8. Given the ADL definitions stated above, please confirm which of the following the Life Assured is able/unable to undertake:

(i) Bathing

Is the Life Assured able, without assistance, to do the following:

Wash? ☐ **YES** ☐ **NO**

Shower? ☐ **YES** ☐ **NO**

Maintain adequate personal cleanliness? ☐ **YES** ☐ **NO**

If not, please state why and how much assistance is required, and on what date the Life Ass became unable to perform these tasks.

(ii) **Dressing**

Is the Life Assured able, without assistance, to dress himself fully? ☐ **YES** ☐ **NO**

Can he unaided, put on and take off medically necessary appliances usually worn? ☐ **YES** ☐ **NO**

If not, please state why and how much assistance is required, and on what date Life Assured became unable to perform these tasks.

(iii) **Using the Lavatory**

Is the Life Assured able to go to the toilet without assistance? ☐ **YES** ☐ **NO**

If not, what is the reason for the Life Assured's restriction and how much assistance is required, and on what date did he become unable to perform these tasks.

(iv) **Eating**

Is the Life Assured able to consume (but not necessarily prepare) food and drink without assistance? ☐ **YES** ☐ **NO**

If not, please give details of the underlying problems and the amount of assistance required, and on what date did the Life Assured become unable to perform these tasks.

(v) **Mobility**

Is the Life Assured able to get in and out of bed or a chair without assistance ? ☐ **YES** ☐ **NO**

If not, please state the reason and how much assistance is required, and on what date the Life Assured became unable to perform these tasks.

9. Do you unequivocally confirm that the Life Assured is suffering from Muscular Dystrophy?

☐ **YES** ☐ **NO**

10. 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

.....

.....