



# 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 the 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 **BACTERIAL MENINGITIS** 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.

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

**32. "Bacterial Meningitis"** : A confirmed diagnosis of Bacterial Meningitis causing inflammation of the membranes of the spinal cord or brain and resulting in permanent neurological deficit as proven to the satisfaction of the Company by a consultant neurologist.  
Bacterial Meningitis resulting from HIV infection is excluded.

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

If 'yes', over what period do your records extend ? .....

2. (i) Date when Life Assured first consulted you for this illness: .....

(ii) Symptoms presented :

(iii) How long had symptoms been present?

(iv) Please describe the full and exact diagnosis of Bacterial Meningitis.

(v) Diagnosis: .....

(vi) Date when illness was first diagnosed: .....

(vii) Diagnosis was first made by: .....

(viii) Date when Life Assured first became aware of the illness: .....

**3. MEDICAL DETAILS**

(a) Has the Life Assured previously suffered from the Bacterial Meningitis or any possible related illness ?  
 YES     NO

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

(b) Please provide details including dates, of the extent of the neurological deficit, and how long this deficit is likely to persist.

(c) Please provide details of investigations performed on the cerebrospinal fluid and blood culture, stating the types of organisms found in each.

(d) Please give details of current treatment.

(e) Please give the name and address of all consultants, specialists or hospitals to which your patient is been referred or attended for this condition.

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

(g) In your opinion, does the condition suffered by the Life Assured fulfil the definition stated below?

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Bacterial Meningitis resulting from HIV infection is excluded.

YES     NO

(h) If there is any further information which, in your opinion, will assist our Chief Medical Officer in assessing this claim, please give details.

Date .....

Signature .....

Name, address and Official Stamp

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