



# 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 **PARALYSIS** 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:-

<b>8. 'Paralysis' (Paraplegia, Tetraplegia)</b>	<b>Clinically certified complete and permanent loss of use of two or more limbs through paralysis as a result of sickness or accident, except when such injury is self-inflicted.</b>
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1. Are you the Life Assured's usual medical attendant ?  YES  NO

Since what date ? Date .....

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

(ii) Symptoms presented:

(iii) How long had symptoms been present?

(iv) Diagnosis : .....

(v) Date when illness was FIRST diagnosed: .....

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

(vii) Has the Life Assured previously suffered from the condition specified above or any possible related illness? If 'yes', please give dates of consultation and the resulting diagnosis.

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

3. (i) Is there permanent loss of voluntary movement of two or more limbs including loss of power and sensation of those limbs, and for how long has this been present?

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(ii) Did paralysis result from complications of surgery, spinal cord injury, Multiple Sclerosis, Motor Neurone Disease or other condition (not including stroke)?

(iii) 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.

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

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

(ii) Is there anything in the Life Assured's family history that would have increased the risk of paralysis?

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

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

8. 'Paralysis' (Paraplegia, Tetraplegia)	:	Clinically certified complete and permanent loss of use of two or more limbs through paralysis as a result of sickness or accident, except when such injury is self-inflicted.
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YES

NO

7. 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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