Family Takaful

CRITICAL ILLNESS (HEART) – STATEMENT OF MEDICAL EXAMINER (GROUP CLAIM)

1. The following named is covered with **ETIQA LIFE INSURANCE BERHAD** against the happening of certain contingents events associated with his/her health. A claim has been submitted in connection with **HEART** and to enable us to assess the claim, we would be obliged if you would complete this Statement of Medical Examiner
2. Any fees chargeable for the completion of this form shall be borne by the claimant.

CONTRACT/ POLICY NO. ……

Name of Participant: ……..

NRIC/Birth Cert No/Passport No: ……

1. Are you the Participant's usual doctor? Yes No

   If yes, since when ..... (dd/mm/yyyy)

2. (a) What were the symptoms **first** presented? ……

   (b) How long had the symptoms been present?.....

3. Please state the exact diagnosis:……

4. When this illness was **first** diagnosed? ..... (dd/mm/yyyy)

5. When was the Participant **first** informed of the diagnosis?..... (dd/mm/yyyy)

6. Has the Participant suffered from this illness or any related illnesses previously? Yes No

   If yes, please give details

Dates of consultation(dd/mm/yyyy)	Diagnosis	Treatment given

7. Please state if there is anything in the Participant's family history which would have increased the risk of this illness.

   ……..

8. (a) Was there a history of typical prolonged chest pain? Yes No

   (b) Date of the **first** onset of episode.....(dd/mm/yyyy)

   (c) Were there any changes in the ECG indicative of a myocardial infarction? Yes No

   (d) Was there a serial elevation of cardiac enzyme (CPK-MB) above normal limit? Yes No

   (e) If yes, please give details

Date of Cardiac Enzyme taken (dd/mm/yyyy)	Cardiac Enzyme/ Biomaker reading	Reading of normal cardiac enzyme

(f) Was coronary arteriography performed? ☐ Yes ☐ No

(g) If Yes, please give details of the results

LOCATION	PERCENTAGE OF NARROWING
Left Main Stem (LMS)	
Left Anterior Descending (LAD)	
Right Coronary Artery (RCA)	
Left Circumflex Artery (LCX)	
Right Circumflex Artery (RCX)	

(f) i. Was coronary bypass surgery performed? ☐ Yes ☐ No

ii. Date of surgery performed .....(dd/mm/yyyy)

iii. Please state the number and sites of grafts inserted. ……...

(g) i. Was angioplasty (PTCA) performed? ☐ Yes ☐ No

ii. Date angioplasty performed ..... (dd/mm/yyyy)

iii. Please state the artery involved: ……..

(I) i. Was heart valve surgery performed? ☐ Yes ☐ No

ii. Date of surgery performed.....(dd/mm/yyyy)

iii. Please state the valve involved……..

(j) i. Was aorta surgery performed? ☐ Yes ☐ No

ii. Date of surgery performed.....(dd/mm/yyyy)

iii. Please state the aorta involved……..

9. Has the Participant suffered from/has been treated for any other illnesses related to / cause for this Critical Illness? ☐Yes ☐ No

If yes, please give full details (diagnosis & date)……

……..

10. Did the Participant consult other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐No

If yes, please give details

Date of Consultation (dd/mm/yyyy)	Name and Address of Hospital / Clinic	Diagnosis / Illness

11. Is there anything in the family history which would have increased the risk of hypertension/diabetes/other vascular/disease/ relevant heart disorders, etc. Yes No If yes, please provide details

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12. Any further information which in your opinion will assist us in assessing theclaim?

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……..

Please furnish copies of all investigation reports including Cardiac Enzyme Assay results (CK-MB), ECG, Troponin T, Coronary Artery Bypass surgery report, Coronary Angiogram report, PTCA report, heart valve surgery report, aorta surgery report and any relevant medical reports that are available.

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief.

…… ……..…….

Signature of Consultant Cardiologist Clinic / Hospital Stamp:

…….... Date: ……..……

Name of Consultant Cardiologist

Professional Qualification: ……..….. Telephone Number……..……