Life Insurance

CRITICAL ILLNESS (HEART) – STATEMENT OF MEDICAL EXAMINER

1. The following named is covered with **ETIQA LIFE INSURANCE BERHAD** against the happening of certain contingent 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.

POLICY NO. ……

Name of Life Assured: ……..

NRIC/Birth Cert No/Passport No: ……

1. Are you the Life Assured'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 Life Assured **first** informed of the diagnosis?..... (dd/mm/yyyy)

6. Has the Life Assured 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 Life Assured'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 reading	Reading of normal cardiac enzyme

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

   If yes, please give details of the results

Location	Percentage (%) of stenosis
Left Anterior Descending (LAD)	
Right Coronary Artery (RCA)	
Left Circumflex Artery (LCX)	
Right Circumflex Artery (RCX)	

(g) 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. ……...

(h) 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 Life Assured suffered from/has been treated for any other illnesses/complaints other than this Critical Illness?

If yes, please give full details. ……

……..

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

If yes, please give details

Date of attendance (dd/mm/yyyy)	Name & address of doctors/hospitals	Illness or condition consulted

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 the claim?

……..

……..

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……..……

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