



Life Insurance

CRITICAL ILLNESS (OTHERS) – 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 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:.....

Claims condition suffered (Please tick (✓) where applicable)

- | | | |
|---|--|---|
| <input type="checkbox"/> Chronic Liver Disease | <input type="checkbox"/> Benign Brain Tumour | <input type="checkbox"/> Paralysis/Paraplegia |
| <input type="checkbox"/> Fulminant Hepatitis | <input type="checkbox"/> Blindness | <input type="checkbox"/> Loss of Hearing/Deafness |
| <input type="checkbox"/> Coma | <input type="checkbox"/> Major Burns | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> AIDS due to Blood Transfusion | <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Major Organ Transplant | <input type="checkbox"/> Loss of Speech | <input type="checkbox"/> Brain Surgery |
| <input type="checkbox"/> Bacterial Meningitis | <input type="checkbox"/> Terminal Illness | <input type="checkbox"/> Major Head Trauma |
| <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Aplastic Anaemia | <input type="checkbox"/> Motor Neuron Disease |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Medullary Cystic Disease | <input type="checkbox"/> Primary Pulmonary Arterial Hypertension | |
| <input type="checkbox"/> Alzheimer's Disease/Irreversible Organic Degenerative Brain Disorder | | |

Name of Life Assured:

NRIC/Birth Cert No/Passport No:

1. Are you the Life Assured's usual Medical Attendant? ☐ Yes ☐ No If yes, since when (dd/mm/yyyy)

Reason for **first** and subsequent consultations:.....

2. (a) Please state the exact diagnosis:
- (b) What was the underlying cause of the diagnosis?
- (c) Date when **first** diagnosis made (dd/mm/yyyy)
- (d) Diagnosis was made by (name of doctor)
- (e) Please provide details of the history of symptoms:.....
- (f) How long had symptoms been present?
- (g) Date when Life Assured **first** became aware of the symptoms (dd/mm/yyyy)
- (h) Date when Life Assured **first** consulted you for the symptoms (dd/mm/yyyy)
- (i) Did the Life Assured consult other doctors for this illness or its symptoms before he /she consulted you? ☐ Yes ☐ No

No If yes, please give details

| Date (dd/mm/yyyy) | Name | Address | Reasons for consultation |
|-------------------|------|---------|--------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

- (j) Is there anything in the Life Assured's family history which would have increased the risk of this illness?

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3. (a) Is the condition a result of an accident? ☐ Yes ☐ No

If yes, please state the date of accident:.....(dd/mm/yyyy) Time of accident(am/pm)

Describe in detail how the accident happened.

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- (b) Was the accident reported to the police? ☐ Yes ☐ No

If yes, please provide the name of the police division and the police officer-in-charge's name.

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(Please enclose a copy of the police report)

- (c) Was the Life Assured under the influence of alcohol/drugs at the time of accident? ☐ Yes ☐ No

No If yes, please state the blood alcohol content/drug type and quantity consumed:

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- (d) Is the condition self-inflicted? ☐ Yes ☐ No If yes, please provide full details:

.....

.....

- (e) Type of treatment including any operations performed and his/her response.

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4. (a) Please provide full address of any hospitals / Clinics to which the Life Assured has been referred together with the names of the consultants attended.

| Date (dd/mm/yyyy) | Hospital / Clinic | Address | Name of consultant |
|-------------------|-------------------|---------|--------------------|
| | | | |
| | | | |
| | | | |

- (b) What tests were performed to confirm the diagnosis?

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(Please enclose certified true copy of all test reports)

- (c) Please describe the nature of treatment and medication prescribed

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- (d) What is the current condition of the Life Assured and what is the prognosis?

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- (e) Has the Life Assured suffered or been treated for any chronic sickness or other than this critical illness? If yes, please give details

| Date(dd/mm/yyyy) | Name & address of doctor | Reason for consultation | Diagnosis |
|------------------|--------------------------|-------------------------|-----------|
| | | | |
| | | | |
| | | | |

5. (a) Last date of consultation (dd/mm/yyyy)

(b) Did the Life Assured suffer any loss of use of limbs? ☐ Yes ☐ No

Please state the power of patient's upper and lower limbs as at last consultation date

| Limb | Power |
|------------------|-------|
| Right upper limb | |
| Left upper limb | |
| Right lower limb | |
| Left lower limb | |

(c) Did the Life Assured suffer any loss of eyes? ☐ Yes ☐ No

Please give details on Life Assured's Visual Acuity as at last consultation; (i) Right eye : (ii) Left eye :

(d) Did the Life Assured suffer any loss of hearing? ☐ Yes ☐ No

Please give details on Life Assured's hearing as at last consultation; (i) Right ear :db (ii) Left ear.....db

(e) Is the Life Assured able to perform all the 6 Activities of Daily Living (ADL) without assistance as at last consultation?

| Activities of Daily Living | Life Assured able to perform | |
|----------------------------|------------------------------|----|
| Transfer | Yes | No |
| Mobility | Yes | No |
| Continence | Yes | No |
| Dressing | Yes | No |
| Bathing/Washing | Yes | No |
| Eating | Yes | No |

6. Any further information which in your opinion will assist us in assessing this claim

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Please attach certified true copies all laboratory test reports e.g. liver function test, CT/MRI report of brain/liver/spine, visual acuity report, medical evidence for usage of life support, audiometry test, sound threshold test result, total body surface assessment, surgery report, biopsy, blood test, pulmonary function test, FEV 1 test and any relevant hospital 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 and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : _____

Name of Doctor : _____

Qualification : _____

Telephone No. : _____ Fax No. : _____ Date : _____ (dd/mm/yyyy)

Official Stamp of Doctor : _____

Name and Address of Clinic / Hospital Official Stamp
