CRITICAL ILLNESS (OTHERS) – 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 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:……..

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

☐ End Stage Liver Failure	☐ Benign Brain Tumour	☐ Paralysis/Paraplegia
☐ Fulminant Viral Hepatitis	☐ Blindness/ Total loss of sight	☐ Loss of Hearing/Deafness
☐ Coma	☐ Major Burns	☐ Multiple Sclerosis
☐ Occupationally Acquired HIV Infection	☐ End Stage Lung Disease	☐ Medullary Cystic Disease
☐ Encephalitis	☐ Loss of Speech	☐ Bacterial Meningitis
☐ Brain Surgery	☐ Terminal Illness	☐ Parkinson's Disease
☐ Major Head Trauma	☐ Chronic Aplastic Anaemia	☐ Primary Pulmonary Arterial Hypertension
☐ Motor Neuron Disease	☐ Muscular Dystrophy	☐ Major Organ/Bone Marrow Transplant
☐ Systemic Lupus Erythematosus with lupus Nephritis	☐ Alzheimer's Disease/Irreversible Organic Degenerative Brain Disorder	☐ Poliomyelitis

Name of Participant: …….

NRIC/Birth Cert No/Passport No: ……

1. Are you the Participant'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 Participant **first** became aware of the symptoms……(dd/mm/yyyy)

   (h) Date when Participant **first** consulted you for the symptoms……..(dd/mm/yyyy)

   (i) 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 (dd/mm/yyyy)	Name	Address	Reasons for consultation

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

   ……

   ……

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.

……

……

……

(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.

……..

……..

(Please enclose a copy of the police report)

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

If yes, please state the blood alcohol content/drug type and quantity consumed:

……..

(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.

……

……

4. (a) Please provide full address of any hospitals / Clinics to which the Participant 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?

……

(Please enclose certified true copy of all test reports)

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

……

……

(d) What is the current condition of the Participant and what is the prognosis?

……..

(e) Has the patient suffered or been treated for any chronic sickness or other than this critical illness? If yes, please give full 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 Participant 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 Participant suffer any loss of eyes? ☐ Yes ☐ No

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

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

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

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

Activities of Daily Living	Participant 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

……...

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

_____ _____