CRITICAL ILLNESS (STROKE) – 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 **STROKE** 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 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. Date when stroke was **first** diagnosed:……(dd/mm/yyyy)

   c. Diagnosis was **first** made by (name of doctor):……..

   d. Please provide details of the history of symptoms:……

   e. How long had symptoms been present? ……..

   f. Date when Participant **first** became aware of the symptoms:……

   g. Date when Participant **first** consulted you for the symptoms:……

   h. Did the Participant consult other doctors for this stroke or its symptoms before he/she consulted you? If yes, please give details

Dates of consultation	Name	Address	Reasons of consultation

3. a. Please describe the initial episode:-

   i. Nature of episode:……..

   ……..

   ii. Date : ……(dd/mm/yyyy)

   iii. Duration of symptoms: ……

   iv. Date of return to normal duties : ……(dd/mm/yyyy)

   v. The Participant's present limitation:

   Physical : ……..

   Mental : ……

   vi. Date of last assessment of Participant: ……(dd/mm/yyyy)

   b. Please provide details on any neurological sequelae and the period it has persisted / lasted after the date of **first** diagnosis made in 2.a : ……

   Are these sequelae permanent? ☐ Yes ☐ No If no, please provide details.

   ……

c. Has there been an infarction of brain tissue cerebral haemorrhage or embolisation? ☐ Yes ☐ No

If yes, please state which of the above is evidenced:

……

……

d. Please provide the 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

e. Are the investigations or findings consistent with the diagnosis of a stroke? ☐ Yes ☐ No If yes, please provide details

……

4. a. Has the Life Assured suffered from/has been treated for any other illnesses related to / cause for this Critical Illness? E.g: transient ischaemic attack, hypertension, diabetes, hypercholesterolaemia, angina pectoris, reversible ischaemic neurological deficit or other vascular disease etc.

☐ Yes ☐ No If yes, please give dates of consultation and the resulting diagnosis.

Date (dd/mm/yyyy)	Name and address of doctor	Reason for consultation	Diagnosis

b. Is there anything in the family history which would have increased the risk of stroke? E.g : hypertension, diabetes, other vascular disease and relevant heart disorders, etc. ☐ Yes ☐ No If yes, please provide details

……

……

c. Please give details of the Participant's past and present smoking habit.

Number of sticks of cigarettes / cigar per day: ……..….. Duration of years of smoking habits:…….. yea(s)

5. If there is any further information, which in your opinion, will assist our Medical Referee in assessing this claim, please furnish such information below: In particular, please confirm whether it is in your opinion that the Participant has sustained permanent neurological deficit or damage or otherwise there has been neurological sequelae of a permanent nature.:

……

……

Please attach certified true copies of radiological, CT scan or MRI of brain and laboratory evidence as well as any other tests. We would be grateful for copies of any other relevant hospital reports that are available. This would help us to process the claim promptly.

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 Consultant Neurologist Clinic / Hospital Stamp:

…….... Date: ……

Name of Consultant Neurologist

Professional Qualification: ……..…….. Tel. No:……..…