CUEPACS TAKAFUL LIVING CARE

RL MAJUSINAR PLUS SDN BHD (1265909-V)

Pejabat:
Bangunan PSM, Level 3, No. 17B, Jalan Bangsar, 59200 Kuala Lumpur.
Tel: 03-22836361 / 22836364 Fax: 03-22836272
H/P : 017-6340518 Email : ctlcplus@yahoo.com

KEPADA

TUAN/PUAN,

TUNTUTAN KRITIKAL
SKIM INSURANS BERKELOMPOK CUEPACS / KOHASIL

Dimaklumkan bahawa untuk tuntutan penyakit kritikal pihak kami memerlukan dokumen berikut untuk proses selanjutnya :-

1. Borang Tuntutan Takaful - Borang Tuntutan Faedah Penyakit Kritikal
2. Borang Tuntutan Takaful - Penyataan Doktor bagi Penyakit Kritikal yang berkenaan
3. Borang Tuntutan Takaful - Surat Pemberikuasa/Kebenaran
4. Salinan Kad Pengenalan/ Sijil Kelahiran yang diakui sah(Pencadang,Orang yang dilindungi & Orang yang menuntut)
5. Bukti Documen bagi hubungan keluarga antara Pencadang , Orang yang Dilindungi dan Orang yang menuntut (ch: Sijil Kelahiran/Sijil Perkhawinan)
6. Laporan Perubatan Tambahan (jika ada)
7. Salinan semua Laporan Makmal dan Penyiasatan yang diakui sah (jika ada)
8. Borang Kemudahaan Kredit Langsung

**** PERHATIAN: SEMUA DOKUMEN HENDAKLAH DIAKUI SAH DARIPADA DOKTOR @ KETUA UNION**

****PERMOHONAN HENDAKLAH DIPOSKAN MENGIKUT ALAMAT KAMI DI BANGSAR DAN PERMOHONAN INI TIDAK BOLEH DIFAKSKAN KEPADA KAMI.**

****PIHAK GETB AKAN MEMINTA DOKUMENTASI TAMBAHAN SEKIRANYA MEMERLUKAN MAKLUMAT LAIN.**

SEKIAN, TERIMA KASIH.

CRITICAL ILLNESS CLAIM FORM - CLAIMANT'S STATEMENT
BORANG TUNTUTAN PENYAKIT KRITIKAL - KENYATAAN PENUNTUT

Great Eastern TAKAFUL

Certificate No. *No. Sijil*	
Certificate No. *No. Sijil*	
Certificate No. *No. Sijil*	
Certificate No. *No. Sijil*	
New NRIC No. *No. KP Baru*	- -
Old NRIC/Birth Certificate/ Passport No. *No. KP Lama/Sijil Kelahiran/No. Pasport*	
Name of Person Covered *Nama Orang yang Dilindungi*	
Contact No. *No. Telefon*	

A. PARTICULARS OF PERSON COVERED *BUTIR-BUTIR ORANG YANG DILINDUNGI*

1. Current correspondence address: *Alamat surat-menyurat terkini:*
   1. ______________________

2. E-mail Address *Alamat E-mel:*
   2. ______________________

3. Nationality *Warganegara:*
   3. ☐ Malaysian *Malaysia* ☐ Non-Malaysian. Please specify: *Bukan Malaysia. Sila nyatakan* ______________________
   Passport No. *No. Pasport:* ______________________
   Passport Expiry Date *Tarikh Luput Pasport:* ______________________ (dd/mm/yyyy) *(hh/bb/tttt)*

4. (a) Occupation *Pekerjaan:*
   (b) The Details of the Employer/ Institute/ School (if student): *Butir-butir Majikan/ Institusi/ Sekolah (jika pelajar):*
   i) Contact No. *No. Telefon:*

   (a) ______________________
   (b) ______________________
   (i) ______________________

5. Does Person Covered have any certificate/ policy with other Takaful Operator/ Insurers?: *Adakah Orang yang Dilindungi mempunyai sijil/ polisi dengan Pengendali Takaful/ Syarikat Insurans yang lain?:*
   If "Yes", please provide the details. *Jika "Ya", sila nyatakan butir-butir tersebut.*

   5. ☐ Yes *Ya* ☐ No *Tidak*

Certificate No./ Polisi No. *No. Sijil/ No. Polisi*	Takaful Operator/ Company *Pengendali Takaful/ Syarikat*

B. NATURE OF CLAIM AND RELATED DETAILS *JENIS TUNTUTAN DAN BUTIR-BUTIR BERKENAAN*

1. Date of Diagnosis: *Tarikh Diagnosis:*
   __ / __ / ____ (dd/mm/yyyy) *(hh/bb/tttt)*

2. Name of illness: *Nama Penyakit:*
   ☐ Cancer *Kanser* ☐ Stroke *Strok*
   ☐ Heart Disease *Penyakit Jantung* ☐ Kidney Failure *Kegagalan Buah Pinggang*
   ☐ Others, please specify: *Lain-lain, sila nyatakan:* ______________________

3. What were the complaint(s)/ ailment(s) of the illness?: *Apakah tanda-tanda penyakit?:*
   ____

4. When did the complaint(s)/ ailment(s) first appear?: *Bilakah tanda-tanda penyakit bermula?:*
   __ / __ / ____ (dd/mm/yyyy) *(hh/bb/tttt)*

5. First visit to doctor *Kali pertama berjumpa doktor*
   __ / __ / ____ (dd/mm/yyyy) *(hh/bb/tttt)*

Great Eastern Takaful Berhad 201001032332 (916257-H)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1 300 13 8338 Fax: +603 4259 8808
E-mail: i-greatcare@greateasterntakaful.com Website: www.greateasterntakaful.com

6. Details of all doctor(s) or specialist(s) who have been consulted due to these complaint(s)/ailment(s) :-
Butir-butir semua doktor atau pakar yang merawat untuk tanda-tanda penyakit :-

Name of Doctor or Specialist *Nama Doktor atau Pakar*	Name and Address of Hospital or Clinic *Nama dan Alamat Hospital atau Klinik*	Date of Visit *Tarikh Rawatan*

Was there any other illness before this?
Pernahkah anda mengalami penyakit lain sebelum ini?

☐ Yes *Ya* ☐ No *Tidak*

If "Yes", please state the other illnesses or conditions. *Jika "Ya", sila nyatakan penyakit atau keadaan lain tersebut.*

7.

Name of Illness *Nama Penyakit*	Name of Doctor or Specialist *Nama Doktor atau Pakar*	Name and Address of Hospital or Clinic *Nama dan Alamat Hospital atau Klinik*	Date of Visit *Tarikh Rawatan*

8. Please provide the name and address of your regular doctor/ clinic if different from above (6) or (7) :-
Sila berikan nama dan alamat pegawai perubatan/ klinik yang anda biasa berjumpa, jika lain daripada (6) atau (7) yang di atas :-

9. Have any of your blood relatives suffered from a similar or related illness?
Pernahkah saudara sedarah anda mengalami penyakit yang serupa atau berkaitan?

☐ Yes *Ya* ☐ No *Tidak*

If "Yes", state the relationship of relatives, nature of illness and the date when the illness was first diagnosed.
Jika "Ya", nyatakan pertalian persaudaraan, jenis penyakit dan tarikh penyakit mula-mula didiagnoskan.

C. DIRECT CREDIT FACILITY *KEMUDAHAN KREDIT LANGSUNG*

Important
Penting

1. By signing this form, you confirm that you have read, understood and agree to the authorisations and declarations printed herein. *Dengan menandatangani borang ini, anda mengesahkan bahawa anda telah membaca, memahami dan bersetuju dengan pengesahan dan pengisytiharan yang dicetak pada muka surat ini.*
2. This Direct Credit facility is only available for direct credit to accounts maintained in banks participating in the Interbank Giro (IBG) payment system in Malaysia. In relation to a *Payee who is a minor, payments shall only be made to accounts maintained by the parent or lawful guardian. *Kemudahan Kredit Langsung ini hanya tersedia untuk kredit langsung kepada akaun yang dikendali oleh bank yang menyertai sistem pembayaran Interbank Giro (IBG) di Malaysia. Berhubung dengan *Penerima Pembayaran bawah umur, bayaran hanya akan dibuat kepada akaun yang dikendalikan oleh ibu bapa atau penjaga yang sah sahaja.*
3. This direct credit facility is not allowed for any joint bank accounts unless the Certificate Owner/ Payee is the primary account holder.
Kemudahan kredit langsung ini tidak dibenarkan untuk sebarang akaun bank bersama melainkan Pemilik Sijil/ Penerima Pembayaran adalah pemegang akaun utama.
4. We reserve the right to make payment by cheque in the event of (a) insufficient/ invalid/ incorrect information being provided in this Direct Credit facility form, (b) payment being made to joint Payees (e.g. joint administrators or joint executors), and/ or (c) the failure of the transfer to the beneficiary bank for any reason whatsoever, (d) If the claim amount exceeds the maximum amount allowed by IBG transaction.
Kami berhak untuk membuat pembayaran dengan cek jika (a) maklumat tidak mencukupi/ tidak sah/ salah diberikan dalam borang kemudahan Kredit Langsung ini, (b) bayaran dibuat kepada Penerima Pembayaran bersama (contohnya pentadbir bersama atau wasi bersama), dan/ atau (c) kegagalan pemindahan kepada bank benefisiari atas apa-apa sebab, (d) Jika jumlah tuntutan melebihi jumlah maksimum yang dibenarkan oleh transaksi IBG.
5. All further claims benefit payable for the same event will be credited into the account below, unless otherwise notified by the certificate owner.
Semua manfaat tuntutan selanjutnya untuk kejadian yang sama akan dikreditkan ke dalam akaun di bawah, kecuali dinyatakan sebaliknya oleh pemilik sijil.

*Payee refers to any person/ company who is the person entitled to the Certificate monies, e.g. Ceritificate Owner, Person Covered, beneficiary, assignee, trustee, Public Trustee/ Amanah Raya Berhad, executor/ executrix, administrator/ administratrix.
**Penerima Pembayaran merujuk kepada mana-mana orang/ syarikat yang merupakan orang yang berhak kepada wang Sijil, cth. Pemilik Sijil, Orang yang Dilindungi, benefisiari, pemegang serah hak, pemegang amanah, Pemegang Amanah Awam/ Amanah Raya Berhad, wasi, pentadbir.*

NAME OF BANK:
NAMA BANK

BANK ACCOUNT HOLDER FULL NAME/ *PAYEE:
NAMA PENUH PEMEGANG AKAUN BANK/ PENERIMA PEMBAYARAN

BANK ACCOUNT NO.:
NO. AKAUN BANK

NRIC (AS PER BANK ACCOUNT):
NO. KP (SEPERTI DALAM AKAUN BANK)

Declaration & Authorisation
Pengisytiharan & Kebenaran

I/ We hereby:
Saya/ Kami dengan ini:

1. Authorise Takaful Operator to credit the amount payable to me under the above certificate into this account. I further confirm that I am the Account holder and have full power and authority to operate the Account [in respect of a partnership or a body corporate].
Membenarkan Pengendali Takaful untuk mengkreditkan jumlah yang perlu dibayar kepada saya di bawah sijil ini ke dalam bank akaun tersebut. Saya selanjutnya mengesahkan bahawa saya adalah pemegang Akaun ini dan mempunyai kuasa penuh dan kuasa untuk mengendalikan Akaun ini [berkenaan perkongsian atau pertubuhan perbadanan].
2. Understand that this standing instruction shall not take effect on any existing transactions that have already been executed and that the Takaful Operator has the right to reject this standing instruction in the event that it is found to be payable to a third party account.
Memahami bahawa arahan tetap ini tidak akan berkuatkuasa pada mana-mana urusniaga sedia ada yang telah dilaksanakan dan bahawa Pengendali Takaful mempunyai hak untuk menolak arahan tetap ini sekiranya ia didapati dibayar kepada akaun pihak ketiga.
3. Agree that the Takaful Operator shall not be liable in the event that any payment transaction into my/ our Account is delayed or cannot be effected due to incorrect or incomplete information being provided in this form, and/ or for any other reason beyond the reasonable control of the Takaful Operator.
Setuju bahawa Pengendali Takaful tidak akan bertanggungjawab sekiranya sebarang transaksi pembayaran ke dalam Akaun saya/ kami ditangguhkan atau tidak dapat dilaksanakan disebabkan oleh maklumat yang tidak betul atau tidak lengkap yang disediakan dalam borang ini, dan/ atau atas sebab lain yang berada di luar kawalan munasabah Pengendali Takaful.
4. Acknowledge and agree that the payment made into the Account shall be a valid discharge of the Takaful Operator's liability under the Certificate. I/ We further agree that the Takaful Operator shall not be held liable for any damages, losses, claims cost and/ or expenses which I/ We may incur as a result of such payments made into the Account in accordance with my/ our instructions herein, including but not limited to the subsequent withdrawal of the Certificate monies from the Account by persons other than myself/ ourselves, and agree to indemnify and to keep the Takaful Operator indemnified of any damages, losses, claims, cost and/ or expenses incurred by the Takaful Operator in defending any claim arising from and/ or in connection with payments made by the Takaful Operator into the Account in accordance with my/ our instructions herein.
Mengakui dan bersetuju bahawa pembayaran yang dibuat ke dalam Akaun adalah pelepasan sah liabiliti Pengendali Takaful di bawah Sijil tersebut. Saya/ kami selanjutnya bersetuju bahawa Pengendali Takaful tidak bertanggungjawab terhadap sebarang kerosakan, kerugian, kos tuntutan dan/ atau perbelanjaan yang saya/ kami mungkin tanggung akibat pembayaran yang dibuat ke dalam Akaun mengikut arahan saya/ kami di sini, termasuk tetapi tidak terhad kepada penarikan balik wang Sijil berikutnya dari Akaun oleh orang selain daripada diri saya/ kami dan bersetuju untuk menanggung rugi dan untuk melindungi Pengendali Takaful daripada apa-apa ganti rugi, kerugian, tuntutan, kos dan/ atau perbelanjaan yang ditanggung oleh Pengendali Takaful dalam mempertahankan sebarang tuntutan yang timbul dan/ atau berkaitan dengan pembayaran yang dibuat oleh Pengendali Takaful ke dalam Akaun mengikut arahan saya/ kami di sini.
5. Agree to immediately refund to the Takaful Operator in full any monies paid into the Account which is paid in error or which I am/ We are otherwise not entitle to receive.
Setuju untuk segera membayar balik kepada Pengendali Takaful dengan sepenuhnya apa-apa wang yang dikreditkan ke dalam Akaun yang dibayar secara tidak sengaja atau yang saya/ kami sebaliknya tidak berhak untuk menerima.
6. Agree that this instruction shall continue to be in force until I/ We expressly revoke the same by executing a new Direct Credit Facility form to replace this Account with a new bank account. However, the Takaful Operator may in its absolute discretion terminate the Direct Credit service at anytime and without assigning any reason(s) therefor.
Setuju bahawa arahan ini akan terus berkuat kuasa sehingga saya/ kami dengan jelas membatalkannya dengan melaksanakan Borang Kemudahan Kredit Langsung baru untuk menggantikan Akaun ini dengan akaun bank baru. Walau bagaimanapun, Pengendali Takaful boleh mengikut budi bicara mutlaknya menamatkan perkhidmatan Kredit Langsung pada bila-bila masa dan tanpa memberikan apa-apa sebab untuknya.

SECTION D. DECLARATION & AUTHORISATION, AUTHORISATION FOR CLAIM MATTERS AND AMENDMENT OF ADDRESS, DATA PROTECTION NOTICE AND DECLARATION & AUTHORISATION FOR ONLINE SUBMISSION FORM
PENGISYTIHARAN & KEBENARAN, KEBENARAN UNTUK PERKARA-PERKARA TUNTUTAN DAN PINDAAN MAKLUMAT ALAMAT, NOTIS PERLINDUNGAN DATA DAN PENGISYTIHARAN & KEBENARAN UNTUK PENYERAHAN BORANG DI ATAS TALIAN

I declare the above answers are true and correct and I agree that If I have made, or shall make any untrue statement, or suppressed or concealed any material fact; my/ Person Covered's right to be compensated shall be absolutely forfeited. I, the Person Covered/ Certificate Owner/ Claimant hereby authorize and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic, takaful operator or insurance company, credit reporting agency, organization, institutions or persons that may have any records or knowledge of my / Person Covered's health or medical history ("Information Provider"), to provide such information to GETB and its authorized service provider and/ or its employee about my personal data, employment and credit information (as defined in Credit Reporting Agencies Act 2010) in order to process my takaful claim. I authorise the Company and its representative to give and release any such information to any party in relation to my application or transaction with the Company for the following purposes (but not limited to): verifying information given pursuant to this claim, background screening, credit evaluation, scoring solutions, administration, analysis or monitoring of certificate with the Company or processing of claim. I, the Person Covered/ Certificate Owner/ Claimant, expressly waive on behalf of myself or any other person who shall have any claim or interest in any certificate hereunder, all provision of law or professional ethics forbidding any Information Provider from disclosing any information acquired while attending to me in a professional capacity.
Saya mengisytiharkan bahawa jawapan di atas adalah betul dan benar serta saya bersetuju jika saya membuat atau akan membuat sebarang kenyataan yang tidak tepat atau menahan atau menyembunyikan sebarang fakta material; hak saya/ Orang yang Dilindungi untuk menerima pampasan akan dilucutkan dengan mutlak. Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut dengan ini membenarkan dan memberi kebenaran kepada mana-mana doktor, pengamal perubatan, pakar perubatan, hospital, makmal, pakar bedah, jururawat, kakitangan perubatan, klinik, Pengendali Takaful atau syarikat insurans, agensi pelaporan kredit, organisasi, institusi atau individu yang mungkin mempunyai sebarang rekod atau pengetahuan berkenaan kesihatan atau sejarah kesihatan saya/ Orang yang Dilindungi ("Pemberi Maklumat") bagi menyediakan maklumat tersebut kepada GETB dan penyedia perkhidmatan berdaftar dan/ atau pekerjanya bagi memproses maklumat data peribadi, pekerjaan, dan maklumat kredit saya (seperti yang ditakrifkan dalam Akta 2010 Agensi Pelaporan Kredit (APK) bagi memproses tuntutan Takaful saya. Saya memberi kuasa kepada Pengendali Takaful dan wakilnya untuk memberi dan mengeluarkan sebarang maklumat kepada mana-mana pihak yang berkaitan dengan permohonan saya atau transaksi dengan Syarikat untuk tujuan berikut (tetapi tidak terhad kepada): mengesahkan maklumat yang diberikan berdasarkan tuntutan ini, pemeriksaan latar belakang, penilaian kredit, penyelesaian pemarkahan, pentadbiran, analisis atau pemantauan sijil dengan Syarikat atau pemprosesan tuntutan. Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut, bagi pihak saya atau mana-mana individu yang mempunyai sebarang tuntutan atau kepentingan dalam mana-mana sijil di bawah ini, mengetepikan semua peruntukan undang-undang atau etika profesional yang melarang mana-mana Pemberi Maklumat daripada mendedahkan sebarang maklumat yang diperlukan semasa memberi perkhidmatan kepada saya dalam kapasiti sebagai seorang profesional.

I, the Person Covered/ Certificate Owner/ Claimant, hereby authorise and give my consent, to the deduction of monies due to the Company from the claim proceeds payable pursuant to any certificate hereunder, including but not limited to any Advance Contribution Account (ACA), contribution due, advance benefit paid, and/ or erroneous or payment made in excess of any claim amount. I, the Person Covered/ Certificate Owner/ Claimant, hereby authorised and give consent to the Company to amend my addresses as provided in this claim form. This authorisation shall irrevocably bind my successors and assignees and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be effective and valid as the original. I, the Person Covered/ Certificate Owner/ Claimant agree that the personal data provided in this form may be used, recorded, stored, archived, disclosed or otherwise processed by the Takaful Operator for the purposes relating to the payment of funds in accordance with my/ our instruction herein, and for the purposes of compliance with any legal or regulatory requirements. I consent that my personal information may be used, recorded, stored, archived, disclosed or otherwise processed by or on behalf of the Takaful Operator (and its successors in title) for the provision of takaful services.
Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut, dengan ini memberi kebenaran dan keizinan untuk menolak wang yang perlu dibayar kepada Syarikat daripada jumlah tuntutan yang boleh dibayar menurut sebarang Sijil di bawah ini, termasuk tetapi tidak terhad kepada sebarang Akaun Sumbangan Pendahuluan, caruman yang perlu dibayar, manfaat yang telah didahulukan dan/ atau pembayaran salah yang dibuat melebihi sebarang amaun tuntutan. Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut, memberi kebenaran dan keizinan kepada Syarikat untuk membuat pindaan maklumat terhadap alamat-alamat saya yang dinyatakan dalam borang tuntutan ini. Kebenaran ini akan terikat kepada pengganti hak milik dan pemegang serah hak tanpa boleh ditarik balik serta kekal sah walaupun selepas saya meninggal dunia atau hilang upaya serta salinan borang ini adalah berkuat kuasa dan sah seperti salinan asal. Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut setuju bahawa data peribadi yang diberi di dalam borang ini mungkin digunakan, direkodkan, disimpan, diarkibkan, dizahirkan atau diproses oleh Pengendali Takaful untuk tujuan berkaitan pembayaran dana sesuai dengan arahan saya/ kami di sini dan untuk tujuan pematuhan sebarang keperluan undang-undang atau peraturan. Saya setuju bahawa maklumat peribadi saya mungkin digunakan, direkodkan, disimpan, diarkibkan, dizahirkan atau diproses oleh atau bagi pihak Pengendali Takaful (dan pengganti hak miliknya) untuk penyediaan perkhidmatan takaful.

Authorisation for Claim Matters and Amendment of Address
Kebenaran untuk Perkara-Perkara Tuntutan dan Pindaan Maklumat Alamat

I, the Person Covered/ Certificate Owner/ Claimant hereby give consent to, GREAT EASTERN TAKAFUL BERHAD (916257-H) ("GETB") Agent or Authorised Person____, Agent Code or New NRIC No. ______________________to assist in matters pertaining to this claim and cheque collection, if any. I hereby agree to release and discharge GETB from all losses, claims, allegations, suits, proceedings, demands, damages, costs and expenses arising from or in connection to the said collection. I further agree to indemnify GETB and to keep GETB fully indemnified from and against any and all such losses, claims, allegations, suits, proceedings, demands, damages, costs and expenses arising from or in connection to the said collection.
Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut, dengan ini memberi kebenaran kepada Ejen GREAT EASTERN TAKAFUL BERHAD (916257-H) ("GETB") atau Pihak yang diberi kuasa, ____ Kod Ejen atau No. KP Baru ______________________________ untuk membantu dalam perkara-perkara berhubungan dengan tuntutan ini dan pengambilan cek, jika ada. Saya dengan ini bersetuju untuk melepaskan GETB dari segala kerugian, tuntutan, tuduhan, guaman, prosiding, permintaan, ganti rugi, kos dan perbelanjaan yang berbangkit dari atau berkaitan dengan pengambilan perkara tersebut. Saya selanjutnya bersetuju untuk menanggung kerugian GETB serta memelihara GETB dengan indemniti sepenuhnya dari atau berkaitan sebarang dan segala kerugian, tuntutan, tuduhan, guaman, prosiding, permintaan, ganti rugi, kos dan perbelanjaan yang berbangkit dari atau berkaitan dengan pengambilan perkara tersebut.

I, the Person Covered/ Certificate Owner/ Claimant ______________________________ NRIC No. ______________
hereby give consent to amend my residential and correspondence addresses stated in this form as follows (please tick ONE box only) :-
Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut ______________________________
No. K.P. ______________ dengan ini memberi kebenaran untuk membuat pindaan maklumat alamat rumah dan alamat surat-menyurat saya seperti di bawah (sila tandakan SATU kotak sahaja) :-

- ☐ I would like to amend the addresses as stated in this form throughout all applicable certificates
  Saya ingin membuat pindaan alamat seperti dinyatakan dalam borang ini untuk semua sijil berkaitan
- ☐ The addresses stated in this form are for this claim transaction only
  Alamat-alamat yang dinyatakan hanyalah untuk transaksi tuntutan ini sahaja

Data Protection Notice
Notis Perlindungan Data

If you have any inquiry such as limiting the processing of certain information, including the withdrawal of consent to the processing of personal information, you may contact our Customer Careline at 1300-13-8338, or write to the Takaful Operator at **i-greatcare@greateasterntakaful.com**.
Sekiranya anda mempunyai sebarang pertanyaan seperti menghadkan pemprosesan maklumat tertentu, termasuk membatalkan persetujuan untuk pemprosesan maklumat peribadi, anda boleh menghubungi talian Careline kami di 1300-13-8338, atau menulis kepada Pengendali Takaful di ***i-greatcare@greateasterntakaful.com***.

If you have any complaints in respect of your personal information, you may contact our Privacy Officer at 603-4259 8381.
Sekiranya anda mempunyai sebarang aduan berhubung dengan maklumat peribadi anda, anda boleh menghubungi Pegawai Privasi kami di 603-4259 8381.

For more information on how the Takaful Operator processes your personal information, please log on to our website **greateasterntakaful.com** and read the Client Charter and Privacy Policy.
Untuk keterangan lanjut mengenai cara Pengendali Takaful memproses maklumat peribadi anda, sila layari laman sesawang kami ***greateasterntakaful.com*** dan baca Piagam Pelanggan dan Dasar Privasi.

Declaration & Authorisation for Online Submission Form
Pengisytiharan & Kebenaran untuk Penyerahan Borang di atas talian

I agree that a copy of documents submitted shall be valid as the original documents and I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the Takaful Operator reserve the rights to verify the documents submitted for the purpose of processing my claims and agree to provide the original and fair copy of the documents to the Takaful Operator whenever requested.
Saya bersetuju bahawa salinan dokumen dikemukakan adalah sah seperti salinan asal dan saya mengesahkan bahawa maklumat yang diberi melalui penyerahan borang di atas talian adalah yang terbaik dari pengetahuan dan kepercayaan saya, benar dari segala aspek. Saya faham bahawa Pengendali Takaful berhak untuk mengesahkan dokumen untuk tujuan pemprosesan tuntutan saya dan bersetuju untuk memberi salinan asal dan salinan yang adil kepada Pengendali Takaful apabila diminta.

I understand that the making of a fraudulent claim by providing untrue or false information is a criminal offence likely to lead to prosecution. Further, I understand and agree that the Takaful Operator shall have the absolute right to recover the claim amount in full from me if there is any untrue or inaccurate representation on the information provided or submission of tampered or false or untrue information had been submitted for the claim.
Saya faham bahawa membuat penipuan tuntutan dengan mengemukakan maklumat tidak benar atau salah adalah kesalahan jenayah berkemungkinan membawa kepada pendakwaan. Selanjutnya, saya faham dan bersetuju bahawa Pengendali Takaful mempunyai hak mutlak meminta jumlah tuntutan sepenuhnya daripada saya jika terdapat sebarang maklumat yang diberikan adalah tidak benar atau tidak tepat atau penyerahan maklumat yang diusik atau maklumat yang dikemukakan adalah salah atau tidak benar untuk tuntutan.

NOTE: If Person Covered/ Certificate Owner/ Claimant is unable to sign due to disability, the thumbprint has to be witnessed by the attending doctor or our authorised officers at any nearest office.
***NOTA**: Sekiranya Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut tidak dapat menandatangani disebabkan oleh hilang upaya, cap ibu jari perlu disaksikan oleh doktor atau pihak yang diberi kuasa di mana-mana cawangan berdekatan.*

Name *Nama:* ______________________

NRIC No./ Passport No.: ______________________
No. KP Baru/ No. Passport

Date *Tarikh:* ______________________

Signature of Person Covered
Tandatangan Orang yang Dilindungi

Name *Nama:* ______________________

NRIC No./ Passport No.: ______________________
No. KP Baru/ No. Passport

Contact No. *No. Telefon:* ______________________

Address *Alamat:* ______________________

____

Email *Emel:* ______________________

Date *Tarikh:* ______________________

Relationship with the Person Covered: ______________________
Hubungan dengan Orang yang Dilindungi

Signature of Certificate Owner/ Claimant
Tandatangan Pemilik Sijil/ Pihak yang Menuntut
If different from the Person Covered
(Jika lain daripada Orang yang Dilindungi)

Name *Nama:* ______________________

NRIC No./ Passport No.: ______________________
No. KP Baru/ No. Passport

Contact No. *No. Telefon:* ______________________

Address *Alamat:* ______________________

____

Email *Emel:* ______________________

Date *Tarikh:* ______________________

Signature of Witness
Tandatangan Saksi

Requirement Checklist for Family Claims Submission

Great Eastern TAKAFUL

Dear Members of Field Force,
You are advised to use this checklist as a guide on the documents required for the claim filed. You may obtain a copy of this checklist from Agent Service Centre, Form Counter or Servicing Branch and i-Greatpartner.

Important Notes :

1. **Please ensure that these requirements are fully complied with in order for us to assess the claim without delay.**
2. **Group Manager (GM) or Unit Manager (UM) may certified all claims documents with the exception of claims incurred outside of Malaysia where the confirmation of the claim event and all other related and relevant documents issued by the Foreign Authority must be certified by the Malaysian Embassy or a Public Notary. Full passport book is required for all foreign claims.**
   Please ensure that at all times, all certified copies of the claim document are duly signed and stamped with the name and rank of the GM or UM.
3. **Submit this Requirement Checklist with the claim submission and tick the checkbox for documents submitted.**
4. **The Takaful Operator may request for additional documents/reports if deemed necessary.**

Certificate No. : ____________ **Branch :** ____________ **Agent's signature :** ____________
Participant/Person Covered : ____________ **Agent/Contact No. :** ____________ **Date :** ____________

Direct Credit

- ☐ Direct Credit Facility Form
- ☐ Copy of NRIC
- ☐ Copy of bank statement / first page of bank passbook with account details

Death Claims

- ☐ Death Claim Form - Claimant's Statement
- ☐ CTC Death Certificate
- ☐ CTC Claimant's NRIC
- ☐ CTC Deceased's NRIC
- ☐ CTC of Embarkment Certificate
- ☐ CTC Marriage Certificate if Claimant is spouse
- ☐ CTC Birth Certificate of Claimant if Claimant is child
- ☐ CTC Birth Certificate of Deceased if Claimant is parent
- ☐ Original copy of Letter of Authorisation/Consent (3 copies)
- ☐ Confirmation letter from National Registration Department (for overseas death claims)

Important Notes

i. If cause of death is unknown, the Takaful Operator will advise further on receipt of the Death Certificate.
ii. For foreign Death Claim, CTC full passport book / Citizenship Certificate are required.

Additional requirements on accidental death

- ☐ Accidental Death Benefit (ADB) Claim Form
- ☐ CTC Police Report
- ☐ CTC Detailed Post Mortem Report
- ☐ CTC of Toxicology Report, if any
- ☐ Newspaper Cutting, if any
- ☐ Others : ____________

Death due to natural causes

- ☐ Doctor's Statement (for policy less than 5 years from date of commencement or from date of reinstatement, whichever is the later)

Total & Permanent Disability Claims

- ☐ TPD Claim Form - Claimant's Statement
- ☐ TPD Claim Form - Doctor's Statement
- ☐ Original copy of Letter of Authorisation/Consent (3 copies)
- ☐ CTC Employment Termination Letter, if applicable
- ☐ CTC Person Covered's NRIC
- ☐ CTC Claimant's NRIC (if different from Person Covered)
- ☐ CTC Clinic/Hospital Consultation Card
- ☐ CTC EPF Withdrawal letter, if applicable
- ☐ CTC SOCSO Offer Letter/ SOCSO "Keputusan Jemaah Doktor Mengenai Keilatan", if applicable
- ☐ CTC of all relevant diagnostic test results or reports
- ☐ CTC Police Report **(accidental cause)**
- ☐ Newspaper Cutting **(accidental cause)**, if applicable
- ☐ Others : ____________

Accident Rider Claims

- ☐ Accident Claim Form - Claimant's Statement
- ☐ Accident Claim Form - Attending Physician's Statement
- ☐ CTC Person Covered's NRIC
- ☐ CTC Claimant's NRIC (if different from Person Covered)
- ☐ Original/CTC Medical Certificates
- ☐ CTC Police Report, if applicable
- ☐ CTC Hospital bill(s) and Payment Receipt(s)
- ☐ Original Bills and original Payment Receipts (applicable to reimbursement claims)
- ☐ CTC of X-ray, MRI, CT scan or other radiology reports
- ☐ Others : ____________

Critical Illness Claims

- ☐ Critical Illness Claim Form - Claimant's Statement
- ☐ Confidential Medical Certificate (Cancer)
- ☐ Confidential Medical Certificate (Brain, Nerve & Muscle related condition) - to be completed by Consultant Neurologist
- ☐ Confidential Medical Certificate (Heart related conditions)
- ☐ Confidential Medical Certificate (Other Illnesses)
- ☐ Original copy of Letter of Authorisation/Consent (3 copies)
- ☐ CTC of Person Covered's NRIC
- ☐ CTC Claimant's NRIC (if different from Person Covered)
- ☐ CTC of all relevant diagnostic test results or reports for individual Covered Event (please refer to the list of Covered Events on the reverse side)
- ☐ Others : ____________

For Office Use
Checked By : ____________
Check Date : ____________

Note : CTC = Certified True Copy

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Great Eastern Takaful Berhad 201001032332 (916257-H)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Telephone: +603 4259 8338 Fax: +603 4259 8808 Customer Service Careline: 1 300 13 8338
E-mail: i-greatcare@greateasterntakaful.com Website: www.greateasterntakaful.com

LIST OF COVERED EVENTS AND THE REQUIRED MEDICAL EVIDENCE

1. **Heart Attack**
   - Cardiac Enzymes Assay results (CK-MB, Troponin T / Troponin I)
   - ECG tracing
   - Echocardiogram / Coronary Angiogram report

2. **Stroke**
   - CT Scan / MRI Report of Brain
   - * CMC to be completed by Consultant Neurologist

3. **Coronary Artery Disease Requiring Surgery**
   - Coronary Artery By-Pass Surgery Report

4. **Cancer**
   - Histopathology Report
   - CT Scan / MRI Reports, if available
   - Bone Marrow Aspiration / Trephine Biopsy Report (Leukemia only)
   - Blood and laboratory test report

5. **Kidney Failure**
   - Kidney Dialysis Report / Dialysis Receipts
   - Kidney transplantation report
   - Blood test results
   - * CMC to be completed by Consultant Nephrologist

6. **Fulminant Viral Hepatitis**
   - CT Scan Report of Liver
   - Liver Function Test results
   - Abdominal ultrasound
   - Hepatitis viral serology test
   - Any other laboratory or pathology reports

7. **Major Organ Transplant**
   - Surgery Report

8. **Paralysis / Paraplegia**
   - X-ray/CT Scan/ MRI Reports, if available

9. **Multiple Sclerosis**
   - CT Scan & MRI Report of Brain & Spine
   - Nerve conduction study / Evoked potential test
   - * CMC to be completed by Consultant Neurologist

10. **Primary Pulmonary Arterial Hypertension**
    - All clinical and laboratory investigation results including cardiac catheterization
    - Echocardiogram report

11. **Blindness**
    - Visual Acuity Report on both eyes to be done by an ophthalmologist
    - * CMC to be completed by an Ophthalmologist.

12. **Heart Valve Replacement**
    - Heart Valve Surgery Report

13. **Loss of Hearing / Deafness**
    - Pure Tone Audiometry Test and Sound Threshold Test results
    - Brainstem Auditory Evoked Response (BAER) report

14. **Surgery to Aorta**
    - Aorta Surgery Report

15. **Loss of Speech**
    - Laryngoscopy report
    - * CMC to be completed by speech pathologist/therapist

16. **Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorder**
    - All relevant investigation results in support of the diagnosis

17. **Major Burns**
    - Total Body Surface Area Burn Assessment Report

18. **Coma**
    - * CMC to be completed by Consultant Neurologist

19. **Terminal Disease**
    - All relevant investigation results in support of the diagnosis

20. **Motor Neuron Disease**
    - CT Scan/ MRI report of the Brain and Spine
    - Electromyography (EMG) test results
    - All relevant investigation results in support of the diagnosis
    - * CMC to be completed by Consultant Neurologist

21. **HIV Infection due to Blood Transfusion**
    - HIV antibody test by ELISA method on the date of blood transfusion
    - HIV antibody test by ELISA method 3 - 6 months from date transfusion
    - Statement from statutory Health Authority to confirm that the disease was medically acquired.
    - Western Blot test

22. **Parkinson's Disease**
    - All relevant investigation results in support of the diagnosis
    - * CMC to be completed by Consultant Neurologist

23. **Chronic Liver Disease**
    - Liver Function Test
    - CT Scan of Liver
    - All laboratory, pathology, hepatitis screening, ultrasound & histology reports

24. **Chronic Lung Disease**
    - Pulmonary Function Test results
    - Arterial Blood Gas test results
    - FEV 1 Test results
    - Relevant investigation results

25. **Major Head Trauma**
    - CT Scan / MRI Report of Brain
    - Surgery report
    - Police report, if any

26. **Aplastic Anemia**
    - Bone Marrow Aspiration Report
    - Blood transfusion records
    - Bone Marrow transplant report
    - Full Blood Picture reports

27. **Muscular Dystrophy**
    - Lumbar puncture
    - Electromyography (EMG) test results
    - Muscles biopsy
    - All relevant investigation results in support of the diagnosis
    - * CMC to be completed by Consultant Neurologist

28. **Benign Brain Tumor**
    - CT Scan / MRI Report of Brain
    - Histopathology Report, if available

29. **Encephalitis**
    - CT Scan / MRI Report of Brain
    - * CMC to be completed by Consultant Neurologist

30. **Poliomyelitis**
    - Diagnostic test results
    - * CMC to be completed by Consultant Neurologist

31. **Brain Surgery**
    - Brain Surgery Report

32. **Bacterial Meningitis**
    - CT Scan / MRI Report of Brain & Spine
    - Lumbar puncture test report

33. **Other Serious Coronary Artery Disease**
    - Coronary Angiogram Report

34. **Apallic Syndrome**
    - CT Scan / MRI Report of Brain
    - * CMC to be completed by Consultant Neurologist

35. **AIDS Cover for Medical Staff**
    - HIV antibody test by ELISA method within 5 days of the event/accident
    - HIV antibody test by ELISA method 3 - 6 months from date of blood transfusion.
    - Statement from statutory Health Authority to confirm that the disease was occupationally acquired.
    - Western Blot test

36. **Full Blown AIDS**
    - HIV antibody test by ELISA method
    - Western Blot Test
    - CD4 Cell Count
    - All serial Full Blood Picture blood test results
    - Histopathology examination (HPE)/ Biopsy report for Kaposi sarcoma or Malignant lymphoma
    - CT Scan/ MRI of Brain for Progressive multifocal leukoencephalopathy.
    - Chest X-ray report
    - Sputum C & S report
    - Sputum AFB

** CMC = Confidential Medical Certificate*

LIST OF COVERED EVENTS AND THE REQUIRED MEDICAL EVIDENCE FOR CERTIFICATES INCEPTED YEAR 2012 AND ABOVE

1. Heart Attack
- Cardiac Enzymes Assay results (CK-MB, Troponin T / Troponin I)
- ECG tracing
- Echocardiogram / Coronary Angiogram report

2. Stroke
- CT Scan / MRI Report of Brain
- * CMC to be completed by Consultant Neurologist

3. Coronary Artery By-Pass Surgery
- Coronary Artery By-Pass Surgery Report

4. Cancer
- Histopathology Report
- CT Scan / MRI Reports, if available
- Bone Marrow Aspiration / Trephine Biopsy Report (Leukemia only)
- Blood and laboratory test report

5. End Stage Kidney Failure
- Kidney Dialysis Report / Dialysis Receipts
- Kidney transplantation report
- Blood test results
- * CMC to be completed by Consultant Nephrologist

6. Fulminant Viral Hepatitis
- CT Scan Report of Liver
- Liver Function Test results
- Abdominal ultrasound
- Hepatitis viral serology test
- Any other laboratory or pathology reports

7. Major Organ / Bone Marrow Transplant
- Surgery Report

8. Paralysis / Paraplegia
- X-ray/CT Scan/ MRI Reports, if available

9. Multiple Sclerosis
- CT Scan & MRI Report of Brain & Spine
- Nerve conduction study/ Evoked potential test
- * CMC to be completed by Consultant Neurologist

10. Primary Pulmonary Arterial Hypertension
- All clinical and laboratory investigation results including cardiac catheterization
- Echocardiogram report

11. Blindness / Total Loss of Sight
- Visual Acuity Report on both eyes to be done by an ophthalmologist
- * CMC to be completed by an Ophthalmologist.

12. Heart Valve Surgery
- Heart Valve Surgery Report

13. Deafness / Total Loss of Hearing
- Pure Tone Audiometry Test and Sound Threshold Test results
- Brainstem Auditory Evoked Response (BAER) report

14. Surgery to Aorta
- Aorta Surgery Report

15. Loss of Speech
- Laryngoscopy report
- * CMC to be completed by speech pathologist/therapist

* CMC = Confidential Medical Certificate

16. Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorder
- All relevant investigation results in support of the diagnosis

17. Major Burns
- Total Body Surface Area Burn Assessment Report

18. Coma
- * CMC to be completed by Consultant Neurologist

19. Systemic Lupus Erythematosus (SLE) With Lupus Nephritis
- Lupus Erythematosus (LE) cell blood test results
- Anti-DNA Antibodies
- Urine FEME results over past 6 months
- Renal function tests with eGFR results over past 6 months
- Renal biopsy report

20. Motor Neuron Disease
- CT Scan/ MRI report of the Brain and Spine
- Electromyography (EMG) test results
- All relevant investigation results in support of the diagnosis
- * CMC to be completed by Consultant Neurologist

21. HIV Infection due to Blood Transfusion
- HIV antibody test by ELISA method on the date of blood transfusion
- HIV antibody test by ELISA method 3 - 6 months from date transfusion
- Statement from statutory Health Authority to confirm that the disease was medically acquired.
- Western Blot test

22. Parkinson's Disease
- All relevant investigation results in support of the diagnosis
- * CMC to be completed by Consultant Neurologist

23. End Stage Liver Failure
- Liver Function Test
- CT Scan of Liver
- All laboratory, pathology, hepatitis screening, ultrasound & histology reports

24. End Stage Lung Disease
- Pulmonary Function Test results
- Arterial Blood Gas test results
- FEV 1 Test results
- Relevant investigation results

25. Major Head Trauma
- CT Scan / MRI Report of Brain
- Surgery report
- Police report, if any

26. Chronic Aplastic Anemia
- Bone Marrow Aspiration Report
- Blood transfusion records
- Bone Marrow transplant report
- Full Blood Picture reports

27. Muscular Dystrophy
- Lumbar puncture
- Electromyography (EMG) test results
- Muscles biopsy
- All relevant investigation results in support of the diagnosis
- * CMC to be completed by Consultant Neurologist

28. Benign Brain Tumor
- CT Scan / MRI Report of Brain
- Histopathology Report, if available

29. Encephalitis
- CT Scan / MRI Report of Brain
- * CMC to be completed by Consultant Neurologist

30. Severe Cardiomyopathy
- Echocardiographic report
- Cardiac catherérisation report

31. Brain Surgery
- Brain Surgery Report

32. Bacterial Meningitis
- CT Scan / MRI Report of Brain & Spine
- Lumbar puncture test report

33. Other Serious Coronary Artery Disease
- Coronary Angiogram Report

34. Angioplasty And Other Invasive Treatments For Major Coronary Artery Disease
- Coronary angiogram report
- Percutaneous Coronary Intervention (PCI) or Laser treatment report

35. Loss Of Independent Existence
- CT Scan / MRI report
- Ultrasound report
- Surgery report
- Blood test reports

36. Full Blown AIDS
- HIV antibody test by ELISA method
- Western Blot Test
- CD4 Cell Count
- All serial Full Blood Picture blood test results
- Histopathology examination (HPE)/ Biopsy report for Kaposi sarcoma or Malignant lymphoma
- CT Scan/ MRI of Brain for Progressive multifocal leukoencephalopathy.
- Chest X-ray report
- Sputum C & S report
- Sputum AFB

LETTER OF AUTHORISATION/CONSENT - To Obtain Further Information
SURAT PEMBERIKUASA/KEBENARAN - Untuk Mendapatkan Maklumat Lanjut

Great Eastern TAKAFUL

Certificate No. / *No. Sijil*	New NRIC No. / *No. KP Baru* ______ - ___ - ____
Certificate No. / *No. Sijil*	Old NRIC/BC/Passport No. / *No. KP Lama/Sijil Kelahiran/ Paspot*
Certificate No. / *No. Sijil*	
Certificate No. / *No. Sijil*	Name of Person Covered / *Nama Orang yang Dilindungi*
Certificate No. / *No. Sijil*	

Our Ref: ______________________
Rujukan Kami:

To Whom It May Concern
Kepada Sesiapa Yang Berkenaan

Dear Sir/Madam,
Tuan/Puan,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, takaful operator, or
Saya dengan ini memberi kuasa dan mengizinkan mana-mana pegawai perubatan, doktor, pakar bedah, klinik, hospital, pusat perubatan, pengendali takaful atau

other organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of
organisasi, institut atau orang perseorangan ("Pemberi Maklumat") yang mungkin mempunyai apa-apa rekod atau mengetahui tentang pekerjaan,

the employment, financial, health or medical history of ______________________
kewangan, kesihatan atau sejarah perubatan

("the Certificate Owner") and to provide such information to GREAT EASTERN TAKAFUL BERHAD (916257-H) ("the Takaful Operator") or
("Pemilik Sijil") untuk memberi maklumat kepada GREAT EASTERN TAKAFUL BERHAD (916257-H) ("Pengendali Takaful") atau

its authorised agents and/or employees.
mana-mana ejen/kakitangannya yang diberi kuasa.

I expressly waive on behalf of myself and/or as a next-of-kin of the Certificate Owner and for his/her estate all provisions of law or professional
Saya juga tidak ragu-ragu untuk mengetepikan bagi pihak saya dan/atau sebagai waris terdekat Pemilik Sijil dan untuk harta pusakanya segala peruntukan

ethics forbidding the Information Provider(s) from disclosing any such information acquired on the Certificate Owner in a professional and/or client
undang-undang atau etika profesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai Pemilik Sijil dalam bidang kuasa

capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may arise, in supplying such
sebagai profesional dan/atau pelanggan dan saya juga memberi pelepasan kepada Pemberi Maklumat ejen/kakitangannya daripada apa-apa liabiliti kerana memberi

information requested by the Takaful Operator.
maklumat tersebut kepada Pengendali Takaful.

This authorisation/consent is irrevocable and a copy of it will have the same effect and validity as the original.
Surat pemberikuasa/kebenaran ini adalah muktamad dan salinannya juga memberi hak dan pengesahan yang sama dengan yang asal.

Signature or Thumb Print ______________________
Tandatangan atau Cap Ibu Jari

Name ______________________
Nama

NRIC No ______________________ Date ______________
No KP *Tarikh*

Relationship with the Certificate Owner ______________________
Hubungan dengan Pemilik Sijil

Registration or Admission No. (If hospitalised) ______________________
Pendaftaran atau No. Kemasukan. (Jika masuk hospital)

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Great Eastern Takaful Berhad 201001032332 (916257-H)
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E-mail: i-greatcare@greateasterntakaful.com Website: www.greateasterntakaful.com

7040042164

CONFIDENTIAL MEDICAL CERTIFICATE
(CRITICAL ILLNESS - BRAIN, NERVE & MUSCLE RELATED CONDITION)

Great Eastern TAKAFUL

Certificate No.		New NRIC No.	- -
Certificate No.		Old NRIC/Birth Certificate/ Passport No.	
Certificate No.		Name of Person Covered	
Certificate No.			

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted within the coverage of a Critical Illness benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any medical report fee incurred in completing this form, it will be borne by claimant)

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

- ☐ CT Scan / MRI report of the Brain
- ☐ MRI of Spine
- ☐ Lumbar puncture test report
- ☐ Electromyography (EMG) test results
- ☐ Nerve conduction study/ Evoked potential test
- ☐ Other reports. Please give details: ____________
- ☐ Blood test reports
- ☐ Surgery report
- ☐ Histopathology examination (HPE)
- ☐ Biopsy report

1. Are you the Person Covered's usual medical attendant? ☐ Yes ☐ No
   If "YES", since what date? __ / __ / ____ (dd/mm/yyyy)

2. Has the Person Covered previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?
   ☐ Yes ☐ No
   If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name and Address of Clinic / Hospital

3. Date when Person Covered FIRST consulted you for the illness. __ / __ / ____ (dd/mm/yyyy)

4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Person Covered had been experiencing these symptoms.

Symptoms	Date symptoms first presented (dd/mm/yyyy)
(a)	
(b)	

   What is the source of this information?
   - ☐ Person Covered
   - ☐ Referring doctor
     Name of doctor and hospital / clinic: ____________
   - ☐ Others, please specify: ____________

5. Diagnosis
   (i) Please describe the full and exact diagnosis. (i) ____________
   (ii) Date when the illness was FIRST diagnosed (ii) __ / __ / ____ (dd/mm/yyyy)
   (iii) Diagnosis was FIRST made by (name of doctor and hospital) (iii) ____________
   (iv) Date when Person Covered FIRST became aware of the illness. (iv) __ / __ / ____ (dd/mm/yyyy)

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6. What is the underlying cause of the illness as per diagnosis above?	
7. Type of investigations / tests done to confirm the diagnosis.	
8. Please give details of completed, planned or current treatment for the illness stated above.	
9. Is the Critical Illness associated with any other disorder, for example neurosis, psychiatric illness, HIV infection, etc.?	☐ Yes ☐ No If "YES", please give details.
10. The condition was associated with: (Please elaborate in details)	☐ self-inflicted injury ☐ drug or alcohol misuse ☐ Others:

11. Please tick and complete for the relevant sections:

√ Please tick	Items	Descriptions
☐ Stroke	Cause of stroke:	☐ Infarct ☐ Hemorrhage ☐ Embolus
☐ Parkinson's Disease	(i) Cause of Parkinson's Disease: (ii) Can the condition / illness be controlled with medication?	(i) ☐ Idiopathic ☐ Secondary due to: (ii) ☐ Yes ☐ No
☐ Motor Neuron Disease	Type of Motor Neuron Disease:	☐ Amyotrophic lateral sclerosis ☐ Progressive bulbar palsy ☐ Primary lateral sclerosis ☐ Spinal muscular atrophy
☐ Muscular Dystrophy	Type of Muscular Dystrophy:	☐ Duchenne's ☐ Myotonic ☐ Facioscapulohumeral ☐ Congenital ☐ Others:
☐ Alzheimer's Disease	Type of conditions involved:	☐ Alzheimer's disease ☐ Dementia ☐ Other degenerative brain disorders
☐ Major Head Trauma	What is the exact location and extent of the head injury?	
☐ Coma	(i) How long was the Person Covered in a state of coma, with no response to external stimuli? (ii) Was the coma 'Medically induced'? (iii) How long was the Person Covered on a ventilator?	(i) ______ hours / ______ days since ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) ______ am/pm (ii) ☐ Yes ☐ No (iii) ______ hours / ______ days First on ventilation since : ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
☐ Benign Brain Tumour	(i) Is the tumour life threatening? (ii) Are there signs of increased intracranial pressure? (iii) Has it caused damage to the brain?	(i) ☐ Yes ☐ No If "YES", please give details. (ii) ☐ Yes ☐ No If "YES", please give details. (iii) ☐ Yes ☐ No If "YES", please give details.

√ Please tick	Items	Descriptions
☐ Bacterial Meningitis / Encephalitis	Please provide Cerebrospinal Fluid (CSF) test results	
☐ Brain Surgery	(i) Please state type of surgery: (ii) Reason for surgery: (iii) Was the surgery done due to injuries sustained during an accident? (iv) Please state date of surgery:	(i) ☐ Craniotomy ☐ Craniectomy ☐ Other procedure : ______ (ii) ______ (iii) ☐ Yes ☐ No (iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

12. Please provide us with any other information that will enable the Takaful Operator to assess this claim.

______

______

13. **Neurological Examination report:**

Please state below **(Question a - h)**, the Person Covered's physical and neurological impairments, **based on latest / current assessment:**

Date when neurological impairments were first noted: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Date of latest/current assessment: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(a) Vision (Visual Acuity)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: ______

(b) Hearing (Supported by an Audiometry results)

	Right	Left
Normal		
Impaired		
Scores based on speech reception threshold	dB	dB

Remarks: ______

(c) Function of speech

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Remarks: ______

(d) Cognitive function

☐ Normal
☐ Poor comprehension
☐ Difficult with logic and reasoning
☐ Memory loss

Remarks: ______

(e) General examination findings:

(i) Are there any abnormal movements or abnormal gait? (Please provide full details)	(i)
(ii) Is there any muscle wasting? (Please provide full details)	(ii)
(iii) If there are any other significant examination findings, please provide the details.	(iii)

(f) Examination of the Limbs

Please indicate the **muscle power** of the various joint in the table below with the maximum grade of 5.

Upper Limbs	**Right**	**Left**
Shoulder		
Elbow		
Wrist		
Grip		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

(g) Assessment of Activities of Daily Living

Activities of Daily Living	**Not Limited**	**Limited**	**Incapable**
Transfer (Getting in & out of a chair without physical assistance)			
Mobility (Ability to move from room to room without physical assistance)			
Continence (Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene)			
Dressing (Putting on & taking off all necessary items of clothing without assistance of another person)			
Bathing / Washing (Ability to wash in the bath or shower, including getting in & out of bath or shower or wash by any other means without assistance of another person)			
Eating (All task of getting food into the body without assistance of another person)			

(h) Any other significant neurological examination findings or disability details that are not stated above:

14. What is the prognosis of the Person Covered's neurological impairments?

You may tick (√) more than one.

- ☐ Recovered
- ☐ Stable and improving
- ☐ Progressively worsening
- ☐ No change. Likely to be permanent
- ☐ For Multiple sclerosis - History of multiple exacerbations and remissions. Please indicate number of exacerbations since diagnosis: ______

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and that I have answered the above questions are true and to the best of my knowledge and belief.

Name: ______

Address:

Signature and Official Stamp

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)