

TOTAL & PERMANENT DISABILITY CLAIM DOCTOR'S STATEMENT

Policy No.		New NRIC No.	- -
Policy No.		Old NRIC/Birth Certificate/ Passport No.	
Policy No.			
Policy No.		Name of Life Assured	

The above name is insured with GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted in within the coverage of a Total and Permanent Disability 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)

1. Are you the Life Assured's usual medical attendant?		☐ Yes ☐ No	
If "YES", since what date?		/ / (dd/mm/yyyy)	
2. Has the Life Assured previously suffered from or been detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder, pre-malignant condition, cancer or any other significant illnesses?			
☐ Yes ☐ No			
If "YES", please provide the following:			
Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor
3. (i) Date when Life Assured FIRST consulted you for the illness.		(i) / / (dd/mm/yyyy)	
(ii) Date(s) of subsequent consultation(s) / follow up(s)		(ii)	
4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Life Assured had been experiencing these symptoms.			
Symptoms		Date symptoms first presented (dd/mm/yyyy)	
(a)			
(b)			
What is the source of this information?			
☐ Life Assured			
☐ 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 Life Assured FIRST became aware of the illness.		(iv) / / (dd/mm/yyyy)	
(v) Date when diagnosis was first made to the Life Assured		(v) / / (dd/mm/yyyy)	
(vi) What was the exact information conveyed to the Life Assured?		(vi)	
(vii) What is the underlying cause of the illness for the diagnosis above?		(vii)	

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6. (i) Type of investigations / tests done to confirm the diagnosis (ii) Type of treatments given and his / her response to the treatments.	(i) _____ _____ (ii) _____ _____												
7. (i) Life Assured's occupation before disability (ii) Nature of duties of the occupation in 7 (i) (iii) How does the Life Assured's disability prevent him / her from performing the above listed duties of his / her occupation?	(i) _____ (ii) _____ _____ (iii) _____ _____												
8. Did the Life Assured consult other doctors for this condition or its symptoms BEFORE he / she consulted you? ☐ Yes ☐ No If "YES", please provide the following:													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 33%;">Name of Doctor</th> <th style="width: 33%;">Name of Clinic/Hospital and Address</th> <th style="width: 33%;">Date of First Consultation</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>		Name of Doctor	Name of Clinic/Hospital and Address	Date of First Consultation									
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Question 9 to be completed if disability caused by an accident													
9. (i) Is the condition a result of an accident? (ii) Describe in detail how the accident happened (iii) Was the Life Assured under the influence of alcohol / drug at the time of accident? (iv) Is the condition self-inflicted?	(i) ☐ Yes ☐ No If "YES", please state the date of accident / (dd/mm/yyyy) (ii) _____ _____ (iii) ☐ Yes ☐ No If "YES", please state the blood alcohol content/drug type and quantity consumed. _____ (iv) ☐ Yes ☐ No If "YES", please provide full details _____												
Please complete the Question 11 to 20 based on your latest detailed examination at the date in Question 10.													
10. Last examination / consultation date	/ (dd/mm/yyyy)												
11. Please describe fully the nature of the Life Assured's disabilities.	_____ _____												
12. Vision (Visual Acuity)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th></th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> </tr> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on Metric Acuity</td> <td> </td> <td> </td> </tr> </table> Remarks: _____		Right	Left	Normal			Impaired			Scores based on Metric Acuity		
	Right	Left											
Normal													
Impaired													
Scores based on Metric Acuity													
13. Hearing	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th></th> <th style="width: 15%;">Right</th> <th style="width: 15%;">Left</th> </tr> <tr> <td>Normal</td> <td> </td> <td> </td> </tr> <tr> <td>Impaired</td> <td> </td> <td> </td> </tr> <tr> <td>Scores based on speech reception threshold</td> <td style="text-align: center;">dB</td> <td style="text-align: center;">dB</td> </tr> </table> (Supported by an Audiometry results) Remarks: _____		Right	Left	Normal			Impaired			Scores based on speech reception threshold	dB	dB
	Right	Left											
Normal													
Impaired													
Scores based on speech reception threshold	dB	dB											
14. Function of speech	☐ Clear and understandable ☐ Slurred ☐ Unable to speak Remarks: _____												
15. Cognitive function	☐ Normal ☐ Poor comprehension ☐ Difficult with logic and reasoning ☐ Memory loss Remarks: _____												

16. General examination findings: (i) Are there any abnormal movements or abnormal gait? (Please provide full details) (ii) Is there any muscle wasting? (Please provide full details) (iii) If there are any other significant examination findings, please provide the details.	(i) _____ _____ _____ (ii) _____ _____ _____ (iii) _____ _____ _____
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17. Examination of the Limbs

(i) 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		

Remarks: _____

(ii) Please indicate the Range of Movement of the various joint in the table below.

Upper Limbs	Right	Left
Shoulder		
Elbow		
Wrist		
Finger(s)		
Lower Limbs	Right	Left
Hip		
Knee		
Ankle		

Remarks: _____

18. 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)			

