CONFIDENTIAL MEDICAL CERTIFICATE
(LIVING ASSURANCE - OTHER ILLNESSES)

Great Eastern
An OCBC Company

Policy No. | | | | | | | | | | |
Policy No. | | | | | | | | | | |
Policy No. | | | | | | | | | | |
Policy No. | | | | | | | | | | |

New NRIC No. | | | | | | | - | | | - | | | | |

Old NRIC/Birth Certificate/ Passport 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 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)

Claims Condition Suffered (Please tick (/) where applicable)

- ☐ Kidney Failure
- ☐ Total Permanent Blindness
- ☐ Total Permanent Deafness
- ☐ Loss of Speech
- ☐ Major Burns
- ☐ Systemic Lupus Erythematosus (SLE) with Lupus Nephritis
- ☐ Fulminant Hepatitis
- ☐ End Stage Liver Disease
- ☐ End Stage Lung Disease
- ☐ HIV Infection From Blood Transfusion
- ☐ AIDS Cover of Medical Staffs
- ☐ Major Organ Transplant
- ☐ Terminal Illness
- ☐ Aplastic Anaemia
- ☐ Full Blown AIDS
- ☐ Loss of Independent Existence

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 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 Life Assured 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 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) What is the underlying cause of the illness as per diagnosis above? (v) _____

GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)
(An OCBC Company)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline : (603) 4259 8333
Website: greateasternlife.com

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(vi) When was the underlying cause FIRST diagnosed?	(vi) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Name of treating doctor and clinic / hospital.
6. Type of investigations / tests done to confirm the diagnosis.	
7. Please give details of completed, planned or current treatment for the illness stated above.	
8. What is the current condition of the Life Assured and what is the prognosis?	

9. Please provide us with any other information that will enable the Company to assess this claim.

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

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

Signature and Official Stamp

Name: _____

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)