

## CRITICAL ILLNESS - STATEMENT OF MEDICAL EXAMINER

**Important Notice:**

- The following named is insured/a policyholder with ETIQA INSURANCE BERHAD/ETIQA TAKAFUL BERHAD and has submitted a claim for critical illness. To allow us to make an assessment of his/her claim, your cooperation is needed to complete this Statement of Medical Examiner.
- Any fees chargeable for the completion of this form shall be borne by the claimant.

### Details of Patient

Policy no.:			
Name of patient:			
MyKad / Army / Police / Passport no.:		Gender:	Age:
Admission Date (dd/mm/yyyy):	Discharge Date (dd/mm/yyyy):		

### General

Type of Illness (please tick whichever is applicable)

<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Terminal illness	<input type="checkbox"/> Major organ failure & transplant
<input type="checkbox"/> Total Blindness	<input type="checkbox"/> Coma	<input type="checkbox"/> Loss of speech	<input type="checkbox"/> Major burns
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Chronic liver disease
<input type="checkbox"/> Surgery to aorta	<input type="checkbox"/> Pulmonary arterial hypertension	<input type="checkbox"/> Heart bypass	<input type="checkbox"/> Aplastic anaemia
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart attack	<input type="checkbox"/> End stage renal failure

Please state the exact diagnosis:			
Please provide details if there is any underlying cause of the diagnosis:			
Is the condition a result of an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was the patient under the influence of alcohol / drugs at the time of accident?	<input type="checkbox"/> Yes, please state the level of alcohol/drugs found in blood/urine:	<input type="checkbox"/> No	
Are you the patient's usual medical attendant?	<input type="checkbox"/> Yes, since:	<input type="checkbox"/> No	
What were the symptoms <b>first</b> presented:			
Date when patient <b>first</b> became aware of the symptoms:			
How long has the symptoms been present?			
Please provide historical details of the symptoms:			
Date when patient <b>first</b> consulted you on the symptoms:			
Date when the illness was <b>first</b> diagnosed:			
Diagnosis was <b>first</b> made by (name of physician):			
Did the patient consult other doctors for this illness or its symptoms before he/she consulted you?	Date(dd/mm/yyyy)	Name & address of physician consulted	Illness or condition consulted
Has the patient suffered from/ been treated for any other illnesses/ complaints other than this Critical Illness?	Date(dd/mm/yyyy)	Name & address of physician consulted	Treatment
			Prognosis
Is there anything in the family history which would have increased the risk of the illness?			
Any other further information which in your opinion will assist us in assessing the claim?			

**Specific Critical Illness Questionnaire (to be completed where applicable)**

**Section A: End Stage Renal Failure**

Please describe the extent of the kidney failure:-

Has the renal disease reached end-stage?	<input type="checkbox"/> Yes, please state the date (dd/mm/yyyy):	<input type="checkbox"/> No		
Which kidney(s) is involved?	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Both		
Is the patient undergoing regular peritoneal dialysis or haemodialysis?	<input type="checkbox"/> Yes, please state the date (dd/mm/yyyy):	<input type="checkbox"/> No		
Please state the frequency of required dialysis per week:				
Has kidney transplant been performed?	<input type="checkbox"/> Yes, please state the date (dd/mm/yyyy) & name of hospital:	<input type="checkbox"/> No		
If the patient was also diagnosed to have High Blood Pressure and/ or Diabetes, please state the recorded blood pressure or diabetes taken on him/ her starting from the first recording done:	Date (dd/mm/yyyy)	Readings of blood pressure	Date (dd/mm/yyyy)	Results for blood glucose (fasting)

**Section B: Cancer**

What were the sites of organ involved and the histology of the tumor?				
What stage did the disease reach? Please describe by using staging classification as appropriate.				
Was it being characterized by uncontrolled growth & spread of malignant cells & invasion of tissue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If the diagnosis is leukemia, please provide details of the actual type:				
When and was a biopsy of the tumor performed?	<input type="checkbox"/> Yes, please state the date:	<input type="checkbox"/> No		
Was the tumor present a result of any human immunodeficiency virus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Please advice the nature of treatment/ test/ procedures that has been carried out and/ or any future intention to do so:	Date (dd/mm/yyyy)	Name of hospital	Treatment	Prognosis

**Section C: Heart Attack/ Heart Bypass/ Surgery to Aorta**

Was there a history of typical prolonged chest pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Date of the <b>first</b> onset episode (dd/mm/yyyy):			
Were there any changes in the ECG indicative of myocardial infarction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there a serial elevation of cardiac enzyme (CPK-MB) above normal limit?	<input type="checkbox"/> Yes, please give details:	<input type="checkbox"/> No	
	Date of cardiac enzyme taken (dd/mm/yyyy)	Cardiac enzyme reading	Reading of normal cardiac enzyme
Was there any radioisotope study of the heart muscle done?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Was coronary arteriography performed?  <input type="checkbox"/> Yes <input type="checkbox"/> No	Location	Percentage (%) of stenosis
	Left Anterior Descending (LAD)	
	Right Coronary Artery (RCA)	
	Left Circumflex Artery (LCX)	
	Right Circumflex Artery (RCX)	
Was coronary bypass surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state the date (dd/mm/yyyy) surgery performed, the no. & sites of graft inserted:	
Was angioplasty (PTCA) performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state the date (dd/mm/yyyy) angioplasty (PTCA) performed & artery involved:	
Was heart valve surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state the date (dd/mm/yyyy) surgery performed & valve involved:	
Was aorta surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please state the date (dd/mm/yyyy) surgery performed & aorta involved:	

### Section D: Stroke

Nature of the episode:	
Date (dd/mm/yyyy):	
Duration of symptoms:	
Date of return to normal duties:	
The present limitation:	
Physical:	
Mental:	
Date of last assessment (dd/mm/yyyy):	
Please provide details on any neurological sequelae and the period it has persisted /lasted after the date of first diagnosis made: (Please provide documented evidence of permanent neurological deficit, if any)	
Are these sequelae permanent?	
Has there been an infarction of brain tissue, cerebral hemorrhage or embolism? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give details:
Please give details of the past and present smoking habit:	Number of sticks of cigarettes/ cigar per day:
	Duration of years of smoking habit:

### Section E: Other Illnesses

Please give details types of treatment including any operations performed:	
What tests were performed to confirm the diagnosis?	
Please describe the nature of treatment and medication prescribed:	
What is the current condition of the patient and what is the prognosis?	
For <b>major burns</b> , please state the degree of burns and percentage (%) of the surface area involved:	
Last date of consultation:	

For <b>Coma and Paralysis</b> , did the patient suffer any loss of use of limbs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For <b>Parkinson's Disease</b> , can the condition be controlled with medication and does it show signs of progressive impairment?		
Please state the power of patient's upper and lower limbs as at last consultation date:	<b>Limb</b>	<b>Power</b>
	Right Upper Limb	
	Left Upper Limb	
	Right Lower Limb	
	Left Lower Limb	
For <b>Total Blindness</b> , did the patient suffer any loss of eyes / total blindness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please give details on Patient's Visual Acuity as at last consultation.	Right eye	Left eye
For <b>Loss of Hearing</b> , did the patient suffer any loss of hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please give details on Patient's hearing as at last consultation	Right ear (db)	Left ear (db)
For <b>Loss of Speech</b> , did the patient suffer any loss of speech?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the loss due to injury or disease to the vocal cords?		
For <b>Major Organ Failure and Transplant</b> , has any major organ transplant (heart, heart & lung, liver, pancreas, kidney or bone marrow) been done?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide details:		
For <b>Multiple Sclerosis</b> , did the patient exhibit neurological abnormalities that have existed for a continuous period of at least six (6) months or having had at least one (1) relapse of such abnormalities? This must be evidenced by the typical symptoms of demyelination and impairment of motor and sensory functions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide details:		
For <b>Alzheimer's Disease</b> , does the patient have deterioration or loss of intellectual capacity or abnormal behaviour?		
For <b>Aplastic Anaemia</b> , does the patient require treatment with at least one of the following: (blood product transfusion / marrow stimulating agents / immunosuppressive agents/ bone marrow transplant)?		
For <b>Chronic Liver Disease</b> , is the condition evidenced by permanent jaundice/ ascites/ encephalopathy?		

### 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 Attending Physician

Clinic/ Hospital Stamp

Date:

Name of Attending Physician & Qualification

Tel. No: