CONFIDENTIAL MEDICAL CERTIFICATE
(GREAT LADY RIDER / MOTHER OR CHILD ILLNESS)

Great Eastern
A member of the OCBC Group

Policy No. / *No. Polisi* ☐☐☐☐☐☐☐☐☐☐
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New NRIC No. / *No. KP Baru* ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐
Old NRIC/BC/Passport No. / *No. KP Lama/Sijil Kelahiran/ Paspot* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of Life Assured / *Nama Hayat yang Diasuranskan* _____

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 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. Date when Life Assured FIRST consulted you. ☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)

3. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 2, and date of onset of these symptoms.

Symptoms	Date of onset of symptoms (dd/mm/yyyy)
(a)	☐☐ ☐☐ ☐☐☐☐
(b)	☐☐ ☐☐ ☐☐☐☐

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

4. Admission details

Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis
☐☐ ☐☐ ☐☐☐☐	☐☐ ☐☐ ☐☐☐☐	
☐☐ ☐☐ ☐☐☐☐	☐☐ ☐☐ ☐☐☐☐	
☐☐ ☐☐ ☐☐☐☐	☐☐ ☐☐ ☐☐☐☐	

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? (v) _____
   (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. _____

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Customer Service Careline: 1-300-1-300-88 Fax: (603) 4259 8000
Email: wecare-my@greateasternlife.com Website: www.greateasternlife.com

SECTION 1 – CHILD ILLNESS / CONDITIONS

Neonatal Jaundice

1.	Date of onset	☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)
2.	Was the Phototherapy administered?	☐ Yes ☐ No
	Phototherapy If "YES", to provide:	Start date (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ / End date (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

3. Please provide Total Serum Bilirubin levels:

Date (dd/mm/yyyy)	**Test**	**Results (µmol/L)**
	Total Serum Bilirubin	

Please attach certified true copy of:

☐ Blood Test Results

Congenital Conditions with Surgery

1.	Diagnosis	_____ _____
2.	Type of surgery	_____
3.	Date of surgery	☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)

Please attach certified true copy of:

☐ Histology report ☐ Surgery report

Premature baby < 37 weeks

1.	Birth weight	_____ gram(s)
2.	Admitted to Neonatal ICU (NICU)	☐ Yes ☐ No

If admitted to NICU, provide dates:

Date of admission (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐	Date of discharge (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

3.	Gestational age at birth	_____ week(s)

Please attach certified true copy of:

☐ Hospital Discharge Summary / Note

☐ Other supporting documents to confirm prematurity

Other Child Abnormalities	
1. Diagnosis	_____
2. Date of diagnosis	☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)
3. Details of abnormalities	_____ _____
4. Treatment details	_____
Please attach certified true copy of: ☐ Confirmatory diagnostic test results	

SECTION 2 – INFECTIOUS DISEASES

Please **TICK** if any of these conditions were diagnosed and provide relevant details:

1.

☐ Chikungunya Fever	☐ Cranial nerve palsy ☐ Guillian-Barre Syndrome ☐ Hepatitis ☐ Meningoencephalitis ☐ Myelitis ☐ Myocarditis ☐ Retinitis ☐ Severe bullous lesions ☐ Uveitis	Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐
Provide details:	_____ _____	

Please attach certified true copy of these reports:

☐ Blood Test to confirm diagnosis
☐ Cardiac MRI
☐ CT / MRI Brain
☐ Echocardiogram
☐ MRI Spine
☐ Ultrasound & CT Abdomen

2.

☐ Creutzfeldt-Jakob Disease	☐ Athetosis ☐ Cerebellar dysfunction ☐ Encephalopathy ☐ Muscular spasm or tremor ☐ Progressive dementia	Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of these reports:

☐ Cerebrospinal Fluid (CSF)
☐ Confirmatory diagnostic test results
☐ CT / MRI Brain
☐ Electroencephalogram (EEG)

3.

☐ Dengue Hemorrhagic Fever	☐ Ascites ☐ Dengue Shock Syndrome ☐ Hypotension < 80mmHg ☐ Pulse pressure ≤ 20mmHg ☐ Oliguria ☐ Metabolic acidosis ☐ Hematocrit increased by 20% or more ☐ Hemorrhagic complications ☐ Hypoproteinemia ☐ Platelet count ≤ 100,000/mm^3 ☐ Pleural effusion	Lowest BP reading: _____ Lowest urine output details: _____

Please attach certified true copy of these reports:

☐ Blood Test to confirm Metabolic Acidosis
☐ Chest X-ray
☐ Dengue Serology
☐ Full Blood Picture with Hematocrit
☐ Liver Function Test
☐ Ultrasound & CT Abdomen

4.

☐ Ebola Virus Infection		Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of:

☐ Confirmatory diagnostic test results

5.

☐ Hand Foot Mouth with Complications	☐ Encephalitis ☐ Myocarditis ☐ Neurological deficit Describe:	Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ _____ _____ Date of onset of neurological deficit (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ Date of recovery (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of these reports:

☐ Cardiac MRI
☐ CT / MRI Brain
☐ Echocardiogram
☐ Viral Test result

6.

☐ Influenza A	☐ H5N1 ☐ H7N9 ☐ Others	Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ If "Others", provide details: _____ _____

Please attach certified true copy of:

☐ Confirmatory diagnostic test results

7.

☐ Japanese Encephalitis		Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of these reports:

☐ Cerebrospinal Fluid (CSF) Culture
☐ Confirmatory diagnostic test result
☐ CT / MRI Brain

8.

☐ Malaria	Malaria Parasite Light Microscopy Blood Film Test	Test results: ☐ < 50,000 parasites/ml ☐ ≥ 50,000 to < 100,000 parasites/ml ☐ ≥ 100,000 parasites/ml

Please attach certified true copy of:

☐ Malaria Parasite Light Microscopy Blood Film Test Result

9.

☐ Measles with complications	☐ Encephalitis ☐ Hepatitis ☐ Pneumonia ☐ Seizures / convulsions	Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ Date of onset (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of relevant test results:

☐ Blood test
☐ Chest X-ray
☐ CT / MRI Brain
☐ Electroencephalogram Report
☐ Liver Function Test Report
☐ Ultrasound / CT Abdomen

10.

☐ Middle East Respiratory Syndrome Coronavirus (MERS-CoV)	Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of these reports:

☐ Confirmatory diagnostic test result
☐ MERS CoV RNA Test

11.

☐ Nipah Virus Infection	☐ Encephalitis	Date of diagnosis (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of these results:

☐ Confirmatory diagnostic test result
☐ CT / MRI Brain

12.

☐ Rabies	☐ Aphasia ☐ Delirium or psychosis ☐ Muscle fasciculation ☐ Seizures	Date of diagnosis (dd/mm/yyyy)

Please attach certified true copy of:

☐ Confirmatory diagnostic test results

13.

☐ SARS	Date of diagnosis (dd/mm/yyyy)

Please attach certified true copy of:

☐ SARS-CoV RNA test report - Two positive test results from two different sources / two different days

14.

☐ Typhoid fever	☐ Delirium or psychosis ☐ Internal bleeding ☐ Intestinal perforation	Date of diagnosis (dd/mm/yyyy)

Please attach certified true copy of these reports:

☐ Blood / Stool Test to confirm infection
☐ Confirmatory diagnostic test results
☐ CT / MRI Abdomen
☐ Widal / Tubex Blood Test

15.

☐ Zika Virus Infection	Date of diagnosis (dd/mm/yyyy)

Please attach certified true copy of:

☐ Confirmatory diagnostic test results

16.

☐ Other Infections with Complications	Date of diagnosis (dd/mm/yyyy) Diagnosis Details of complications Treatment details

SECTION 3 – PREGNANCY COMPLICATIONS / PREGNANCY RELATED CONDITIONS

Please **TICK** if any of these pregnancy complications were present and provide relevant details.

1.

☐ Abruptio placenta	☐ Emergency LSCS ☐ Fetal death	Date of surgery / death (dd/mm/yyyy)

Please attach certified true copy of:

☐ Surgery report (for Emergency LSCS)

2.

☐ Amniotic Fluid Embolism	☐ Cardiac arrest ☐ Fetal death ☐ Life threatening pulmonary oedema	Date of diagnosis / death (dd/mm/yyyy)

Please attach certified true copy of these reports:

☐ Chest X-ray / CT Thorax (for life threatening pulmonary oedema)

☐ ECG Tracing during cardiac arrest (for cardiac arrest)

3.

☐ Eclampsia	☐ Cerebral or visual disturbance ☐ Convulsion / seizures ☐ Elevated creatinine levels ☐ Hypertension To provide the highest BP reading: _____ mm Hg ☐ HELLP Syndrome ☐ Elevated liver enzymes ☐ Haemolytic anaemia ☐ Low platelets ☐ Microangiopathic anaemia ☐ Intrauterine death Gestational period: _____ week(s) ☐ Jaundice ☐ Oligouria ☐ Proteinuria ☐ Pulmonary odema ☐ Thrombocytopenia, coagulopathy	Date of diagnosis / death (dd/mm/yyyy)

Please attach certified true copy of these reports:

☐ 24H Urine Creatinine
☐ 24H Urine Protein
☐ Chest X-ray / CT Thorax
☐ CT / MRI Brain
☐ Electroencephalogram
☐ Full Blood Count
☐ Liver Function Test
☐ PT / APTT
☐ Renal Function Test
☐ UFEME

4.

☐ Placenta Increta / Percreta	☐ Surgical removal of placenta	Date of surgery (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of these reports:

☐ Histology ☐ Ultrasound Uterus

5.

☐ Postpartum Haemorrhage	Due to ☐ Atonic uterus ☐ Large cervical laceration into uterus ☐ Ruptured uterus Was Hysterectomy done? ☐ Yes ☐ No	Date of surgery (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Please attach certified true copy of these reports:

☐ Histology or Surgery report ☐ Ultrasound Uterus

6.

☐ Acute Fatty Liver in Pregnancy	☐ Encephalopathy ☐ Fulminant Hepatic Failure ☐ Liver Disease	Date of diagnosis (dd/mm/yyyy)

Please attach certified true copy of these reports:

☐ CT Abdomen ☐ Ultrasound Abdomen

☐ Liver Function Test

7.

☐ Disseminated Intravascular Coagulation (D.I.C.)	Underlying cause ☐ Due to pregnancy At which gestational age? ☐ Due to other causes (other than pregnancy) Treated with ☐ Frozen plasma ☐ Platelet concentrate ☐ Others:_____	Date of onset (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ ☐ ≤ 12 weeks ☐ 13 – 24 weeks ☐ 25 – 28 weeks ☐ 28 weeks Date treatment commenced

Please attach certified true copy of these reports:

☐ D-dimer ☐ Partial Thromboplastin Time (PTT)

☐ Fibrinogen ☐ Prothrombin Time

☐ Full Blood Picture

8.

☐ Gestational Diabetes Mellitus	☐ Antidiabetic treatment started on ☐ OGTT done on Name of medication	Date of onset (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ Date (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐ _____ _____

Please attach certified true copy of:

☐ OGTT Results

9.

☐ Intrauterine Death of Fetus	☐ Elective Termination of Pregnancy ☐ Medically necessary Reason: ☐ As a result of bodily injury due to accident Details: Gestational age at death	_____ _____ _____ _____ _____ week(s)

10.

☐ Other Pregnancy Complications	Date of diagnosis (dd/mm/yyyy) Diagnosis Details of complications Treatment details	☐☐ ☐☐ ☐☐☐☐ _____ _____ _____ _____ _____ _____

Please attach certified true copy of:

☐ Relevant Diagnostic / Surgery Reports

TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

Signature and Official Stamp

Date: ☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)

Name : _____

Address : _____

_____

_____