TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

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 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	Name and Address of Clinic / Hospital

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) _____

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1300-1300 88 Fax: +603 4259 8000
E-mail: wecare-my@greateasternlife.com Website: greateasternlife.com

 5952467525

6. (i) Type of investigations / tests done to confirm the diagnosis

(i) _____

(ii) Type of treatments given and his / her response to the treatments.

(ii) _____

7. (i) Life Assured's occupation before disability

(i) _____

(ii) Nature of duties of the occupation in 7 (i)

(ii) _____

(iii) How does the Life Assured's disability prevent him / her from performing the above listed duties of his / her occupation?

(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:

Name of Doctor	Name of Clinic/Hospital and Address	Date of First Consultation

Question 9 to be completed if disability caused by an accident

9. (i) Is the condition a result of an accident?

(i) ☐ Yes ☐ No

If "YES", please state the date of accident

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) Describe in detail how the accident happened

(ii) _____

(iii) Was the Life Assured under the influence of alcohol / drug at the time of accident?

(iii) ☐ Yes ☐ No

If "YES", please state the blood alcohol content/drug type and quantity consumed.

_____

(iv) Is the condition self-inflicted?

(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)

	Right	**Left**
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

13. Hearing

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

(Supported by an Audiometry results)

Remarks: _____

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) — (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) _____

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)			

19. (i) Is Life Assured's disability progressively worsening, stagnant or recovering?

(i) _____

(ii) Is full recovery expected?

(ii) ☐ Yes ☐ No

If "YES", please state approximate period taken for full recovery from now.

_____

If "NO", please state the extent of recovery and approximate period taken for the stated extent of recovery from now.

_____

_____

(iii) Is Life Assured confined to a home, hospital or other institution that provides constant care and medical attention?

If "YES", since what date?

(iii) _____

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

20. (i) Is the Life Assured able to perform all the normal duties of his / her usual occupation?

(i) ☐ Yes ☐ No

If "YES", when is he/she expected to return to his/her usual occupation?

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) If he / she is unable to return to his/her usual occupation, is he / she able to engage in any other occupation?

(ii) ☐ Yes ☐ No

(a) What types of occupation can he / she be engaged in?

(a) _____

(b) When is he / she expected to engage in these occupations?

(b) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

21. Is the Life Assured physically or mentally incapacitated from ever continuing in any employment?

☐ Yes ☐ No

If "YES", when did such disability commence?

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

22. Is the Life Assured certified to be Total and Permanent Disabled?

☐ Yes ☐ No

(i) If "YES", when did the Life Assured certified to be Total and Permanent Disabled?

(i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) If the incapacity of the Life Assured cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future?

(ii) ☐ Yes ☐ No

If "YES", when is the next review / examination of the condition scheduled?

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

23. Please provide us with any other additional information that will enable the Company to assess this claim. Please enclose copies of laboratory test result, if any.

_____

_____

_____

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.

Name: _____

Address:

Signature and Official Stamp

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)