

Medical Questionnaire: Alzheimer's Disease / Irreversible Organic

Degenerative Brain Disorders

Name of Life Assured :

NRIC of Life Assured :

Policy No :



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 for Living Assurance 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?

No Yes

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?

No Yes

If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name of Clinic/Hospital and Address

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. (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 symptoms.

(iv) / / (dd/mm/yyyy)

(v) Date when diagnosis was first made to the Life Assured.

(iv) / / (dd/mm/yyyy)

(vi) What was the exact information conveyed to the Life assured.

(vi) _____

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<p>6. (i) Type of investigations / tests done to confirm the diagnosis</p> <p>(ii) Type of treatments given and his / her response to the treatments.</p>	<p>(i) _____</p> <p>_____</p> <p>(ii) _____</p> <p>_____</p> <p>_____</p>
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7. Did the Life Assured consult other doctors for this condition or its symptoms BEFORE he/she consulted you?

No Yes

If "YES", please give name(s) and address(es) of the doctor(s) whom he/she consulted

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

Please complete the Question 9 to 16 based on your LATEST detailed examination of the Life Assured's Alzheimer's Disease/ Irreversible Organic Degenerative Brain Disorders.

8. When was the **LATEST** Psychiatric Examination / Assessment done on the Life Assured?

/

 /

 (dd/mm/yyyy)

9. As Per DSM-IV TR Criteria for Alzheimer's Disease , does the Life Assured exhibit the following symptoms :	Yes	No
a) Memory Impairment – Impaired ability to learn new information or to recall previously learned information	<input type="checkbox"/>	<input type="checkbox"/>
b) Life Assured exhibit one (or more) of the following cognitive disturbances	<input type="checkbox"/>	<input type="checkbox"/>
i. Aphasia (language disturbances)	<input type="checkbox"/>	<input type="checkbox"/>
ii. Apraxia (Impaired ability to carry out motor activities despite intact motor function)	<input type="checkbox"/>	<input type="checkbox"/>
iii. Agnosia (Failure to recognize or identify objects despite intact sensory function)	<input type="checkbox"/>	<input type="checkbox"/>
iv. Disturbances in executing functioning (i.e, planning, organizing, sequencing, abstracting)	<input type="checkbox"/>	<input type="checkbox"/>
c) The cognitive deficits in 9(a) and 9(b) each cause a significant impairment in social and occupational functioning and represent a significant decline from a previous level of functioning of the Life Assured.	<input type="checkbox"/>	<input type="checkbox"/>
d) The clinical course of the disease presented by the Life Assured is characterized with a gradual onset and continuing cognitive decline.	<input type="checkbox"/>	<input type="checkbox"/>

10. As Per DSM-IV TR Criteria for Alzheimer's Disease :	Yes	No
a) The cognitive deficits in 9(a) and 9(b) experienced by the Life Assured are not due to any of the following :	<input type="checkbox"/>	<input type="checkbox"/>
i. Other central nervous systems, conditions that cause progressive deficits in memory and cognition (e.g. cerebrovascular disease, Parkinson's Disease, Huntington's Disease, Sudural Hematoma, normal pressure Hydrocephalus, brain tumour)	<input type="checkbox"/>	<input type="checkbox"/>
ii. Systemic conditions that are known to cause dementia (e.g. hypothyroidism, vitamin B12 or folic acid deficiency, neurosyphilis, HIV infection)	<input type="checkbox"/>	<input type="checkbox"/>
iii. Substance-induced conditions	<input type="checkbox"/>	<input type="checkbox"/>
b) The cognitive deficits in 9(a) and 9(b) experienced by the Life Assured do not occur exclusively during the course of a delirium.	<input type="checkbox"/>	<input type="checkbox"/>
c) The disturbance is not better accounted for by another disorder (e.g. Major Depressive Disorder, Schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>

11. Mini-Mental Status Examination (MMSE)

Maximum Score

Score

Orientation

5 — What is the (year) (season) (date) (day) (month)?

5 — Where are we: (state) (country) (town or city) (hospital) (floor)?

Registration

3 — Name three common objects (e.g., "apple," "table," "penny"):
Take one second to say each. Then ask the patient to repeat all three after you have said them.
Give one point for each correct answer. Then repeat them until he or she learns all three.
Count trials and record.

— Trials: __

Attention and calculation

5 — Spell "world" backwards. The score is the number of letters in correct order.

— (D _ L _ R _ O _ W _)

Recall

3 — Ask for the three objects repeated above. Give one point for each correct answer.
(Noted: recall cannot be tested if all three objects were not remembered during registration)

Language

2 — Name a "pencil" and "watch"

1 — Repeat the following: "No ifs, ands or buts."

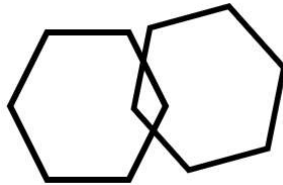
3 — Follow a three-stage command:

1 — "Take a paper in your right hand, fold it in half and put it on the floor."

1 — Close your eyes.

1 — Write a sentence.

Copy the following design.



—
Total
Score

12. Assessment of Clinical Dementia Rating (CDR).

Please score and circle the rating impairment for each category and then to calculate the CDR.

	Impairment				
	None 0	Questionable 0.5	Mild 1	Moderate 2	Severe 3
Memory	No memory loss or slight inconsistent forgetfulness	Consistent slight forgetfulness; partial recollection of events; "benign" forgetfulness	Moderate memory loss; more marked for recent events; defect interferes with everyday activities	Severe memory loss; only highly learned material retained; new material rapidly lost	Severe memory loss; only fragments remain
Orientation	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere	Severe difficulty with time relationships; usually disoriented to time, often to place	Oriented to person only
Judgment & Problem Solving	Solves everyday problems & handles business & financial affairs well; judgment good in relation to past performance	Slight impairment in solving problems, similarities, and differences	Moderate difficulty in handling problems, similarities, and differences; social judgment usually maintained	Severely impaired in handling problems, similarities, and differences; social judgment usually impaired	Unable to make judgments or solve problems
Community Affairs	Independent function at usual level in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently at these activities although may still be engaged in some; appears normal to casual inspection	No pretense of independent function outside home Appears well enough to be taken to functions outside a family home	Appears too ill to be taken to functions outside a family home
Home and Hobbies	Life at home, hobbies, and intellectual interests well maintained	Life at home, hobbies, and intellectual interests slightly impaired	Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned	Only simple chores preserved; very restricted interests, poorly maintained	No significant function in home
Personal Care	Fully capable of self-care		Needs prompting	Requires assistance in dressing, hygiene, keeping of personal effects	Requires much help with personal care; frequent incontinence

Score only as decline from previous usual level due to cognitive loss, not impairment due to other factors.

Clinical Dementia Rating (CDR)	0	0.5	1	2	3
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13. 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)			
Contenance (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)			

14. Is Life Assured requiring the continuous supervision?

Yes No

15. What is the prognosis of the Life Assured's neurological impairments?

Recovered Stable and improving
 Likely to be permanent Progressively worsening

You may tick (√) more than one.

16. 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

I, the undersigned, do hereby declare the above answers are true to the best of my knowledge.

Signature and Official Stamp

Date: / / (dd/mm/yyyy)

Name: _____

Address: _____
