CRITICAL ILLNESS (RENAL FAILURE) – STATEMENT OF MEDICAL EXAMINER (GROUP CLAIM)

1. The following named is covered with **ETIQA TAKAFUL BERHAD** against the happening of certain contingents events associated with his/her health. A claim has been submitted in connection with **END STAGE RENAL FAILURE** and to enable us to assess the claim, we would be obliged if you would complete this Statement of Medical Examiner
2. Any fees chargeable for the completion of this form shall be borne by the claimant.

CONTRACT NO:……..

Name of Participant: … …….

NRIC/Birth Cert No/Passport No: ……

1. Are you the Participant's usual medical attendant? □ Yes □ No

   If yes, since when the Participant has been consulting you? Date : ……(dd/mm/yyyy)

   Reason for **first** and subsequent consultations:…….

2. What were the symptoms **first** presented? ……

   ……..

3. How long had the symptoms been present? ……

4. Please state the exact diagnosis: ……

5. When this illness was **first** diagnosed? Date: …… (dd/mm/yyyy)

6. When was the Participant **first** informed of the diagnosis? Date : ……..,……..…..(dd/mm/yyyy)

7. Has the Participant suffered from this illness or any related illnesses previously? □ Yes □ No

   If yes, please give details of consultation, the diagnosis and treatment given :

Dates of consultation	Diagnosis	Treatment given

8. Please state if there is anything in the Participant's family history which would have increased the risk of this illness.

   ……..

9. Please describe the extent of the kidney failure:-

   a. (i) Has the Participant's renal disease reach end-stage? □ Yes □ No

      (ii) If yes, please state the date ……..(dd/mm/yyyy)

   b. Which kidney (s) is involved? □ Right □ Left □ Both

   c. (i) Is the Participant undergoing regular peritoneal dialysis or haemodialysis? □ Yes □ No

      (ii) If yes, please state the date ……..(dd/mm/yyyy)

      (iii) Please state the frequency of required dialysis per week: ……per week

   d. (i) Has renal transplantation been performed? □ Yes □ No

      (ii) If yes, please state the date and name of hospital. Date: …….. Hospital: ……

10. Has the Participant suffered from/been treated for any other illnesses related to/ cause for this Critical Illness? □ Yes □ No

    If yes, please give full details (diagnosis & date) …….

    ……..……

11. Did the Participant consult other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐ No

If yes, please give details.

Date (dd/mm/yyyy)	Name & address of hospital	Name of doctors	Illness or condition consulted

12. If the Participant was 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)

13. Any further information which in your opinion will assist us in assessing the claim?

……..

……

Please furnish certified true copies of all investigation reports including dialysis report or receipts, blood tests, cytoscopy, pyelograms, ultrasound, biopsy reports, other laboratory reports, surgical procedure, etc. and any relevant medical reports that are available.

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief.

Signature: _____

Name of Nephrologist: _____

Professional Qualification (s): _____

Name of Hospital/Clinic: _____

Address: _____

_____

Telephone no: _____ Official Stamp of Hospital/Clinic

Fax no: _____

E-mail: _____

Date: _____ _____

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