TOTAL & PERMANENT DISABILITY CLAIM - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries sustained or illnesses diagnosed.
2. Completion of Section B must be done **six months** after the diagnosis date.
3. Expenses incurred to obtain this report will be borne by the Participant.

CONTRACT NO:……

Name of Participant:……..

NRIC/Birth Cert No/Passport No: ……

1. Are you the Participant's regular doctor? ☐ Yes ☐ No If yes, since what date ?.....(dd/mm/yyyy)
2. a. Date of **first** consultation for the current condition: ……(dd/mm/yyyy)

   b. Date(s) of subsequent consultation(s)

Date of consultation (dd/mm/yyyy)	Treatment given	Healing progress

   c. Please state the symptoms presented and date symptoms **first** appeared

Symptoms presented at first consultation	Date symptoms first started (dd/mm/yyyy)

   i) What is the source of this information? ☐ Participant ☐ Referring Doctor ☐ Others

   If "Others", please specify the name of the person and relationship to the Participant.

   ……

   d. Diagnosis:……

   ……

   ……

   e. Date of **first** diagnosis: ……(dd/mm/yyyy)

   f. Diagnosis was **first** made by (name of doctor):……(dd/mm/yyyy)

   g. Date diagnosis was made known to the Participant:……..(dd/mm/yyyy)

   h. What was the exact information conveyed to the Participant?

   ……...

3. a. Participant's occupation before disability:……

   b. Nature of duties of current occupation:……

   ……

c. How does the Participant's disability prevent him from performing the above listed duties of his/her occupation?

……

……

4. a. Is the condition a result of an accident? ☐ Yes ☐ No

If yes, please state the date of accident:……..(dd/mm/yyyy) Time of accident:……..(am/pm)

Describe in detail how the accident happened.

……...

……...

……...

b. Was the accident reported to the police? ☐ Yes ☐ No

If yes, please provide the name of the police division and the police officer-in-charge's name.

……

……

(Please enclose a copy of the police report)

c. Was the Participant under the influence of alcohol/drugs at the time of accident? ☐ Yes ☐ No

If yes, please state the blood alcohol content/drug type and quantity consumed:

……

d. Is the condition self-inflicted? ☐ Yes ☐ No If yes, please provide full details:

……

……

e. Type of treatment including any operations performed and his/her response.

……...

……

5. a. Please describe fully the nature and severity of the Participant's disabilities.

……

……

b. Is his /her disability progressing, stagnant or recovering?

……

c. Is full recovery expected? ☐ Yes ☐ No If yes, please state approximate date: ……..(dd/mm/yyyy)

If no, please state the extent of recovery and approximate date of the stated extent of recovery

……

……

d. Is the Participant able to perform all the 6 Activities of Daily Living (ADL) without assistance?

Activities of Daily Living	Participant able to perform	
Transfer	Yes	No
Mobility	Yes	No
Continence	Yes	No
Dressing	Yes	No
Bathing/Washing	Yes	No
Eating	Yes	No

e. Is Participant confined to a home/hospital or other institution that provides constant care and medical attention?

☐ Yes ☐ No If yes, since what date:…….. ..(dd/mm/yyyy)

f. Does the patient suffer any loss of use of limbs or/and fingers? ☐ Yes ☐ No

Please state the power of patient's upper and lower limbs

i. Right Upper Limb : …….. Right Lower Limb :……..

ii. Left Upper Limb : ……. Left Lower Limb : ……..

g. Did the patient suffer amputation of limbs or/and fingers? ☐ Yes ☐ No

If yes, please stated level of amputation seen (proximal, middle, distal) …….

h. Did the patient suffer any loss of eyes? ☐ Yes ☐ No

Please give details on Insured's Visual Acuity; (i) Right eye : …… (ii) Left eye : …….

i. Did the patient suffer any loss of hearing? ☐ Yes ☐ No

If yes, please give details on Insured's hearing, (i) Right ear : ……...db (ii) Left ear : ……db

j. Please give full details with respect to the Participant's mental abilities and cognition.

……

……

k. Is the Participant able to perform all the normal duties of his/her usual occupation? ☐ Yes ☐ No

If yes, when is he/she expected to return to his usual occupation? ……..(dd/mm/yyyy)

l. If Participant is unable to return to his/her usual occupation, is he/she able to engage in any other occupation?

☐ Yes ☐ No If yes, what type of occupation can he/she be engaged in?

……

m. When is Participant expected to engage in these occupations? ……..……(dd/mm/yyyy)

6. a. Did the Participant consult other doctors for this condition or its symptoms BEFORE he/she consulted you?

☐ Yes ☐ No 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 (dd/mm/yyyy)

b. Is the Participant suffering or has suffered from any other significant illnesses?

☐ Yes ☐ No If yes, please state.

Illness	Date of First Diagnosis (dd/mm/yyyy)	Name and Address of Attending Doctor

c. i. Is the Participant physically or mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

ii. If yes, when did such disability commence? ……(dd/mm/yyyy)

d. Is the Participant terminally ill? ☐ Yes ☐ No

7. If the incapacity of the Participant cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future? ☐ Yes ☐ No

If yes, what is the appropriate time period for the Company to re-assess this claim? ……..(dd/mm/yyyy)

8. Please provide us with any other additional information that will enable the Company to assess this claim. Enclose copies of laboratory tests results, if any.

……...

……...

……...

DECLARATION:

I,…….. the undersigned, do hereby declare the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company. Furthermore, I certify that I have personally examined the identity of the above-named Participant and the facts as stated above represent my medical opinion of his/her condition.

…… ……

Signature of the Attending Physician Date (dd/mm/yyyy)

…… ……

Name of the Attending Physician Contact No.

…….. ……

Professional Qualification Official Stamp and Address

Etiqa Takaful Berhad (266243D)
Level 19, Tower C, Dataran Maybank, No 1, Jalan Maarof, 59000 Kuala Lumpur
T +603 2297 3888 **F** +603 2297 3800 **E** info@etiqa.com.my www.etiqa.com.my