PRUDENTIAL BSN TAKAFUL

CONFIDENTIAL MEDICAL CERTIFICATE
(TOTAL AND PERMANENT DISABILITY CLAIM)

SIJIL PERUBATAN SULIT
(TUNTUTAN KETIDAKUPAYAAN PENUH DAN KEKAL)

To be completed free of the Company's expenses by the Medical Attendant of the Person Covered.
Untuk dilengkapkan tanpa melibatkan perbelanjaan Syarikat, oleh Perawat Perubatan Orang Dilindungi

Name /
Nama

Date of birth:
Tarikh Lahir

Certificate No:
No. Sijil

The above named is covered with Prudential BSN Takaful Berhad against the happening of certain contingent events associated with his/her health. A claim has been submitted in respect of Total & Permanent Disability and, to enable us to assess the claim, we would be obliged if you would complete this Confidential Report according to your personal knowledge and his/her medical records and return it direct to us.

In order for the claim to be valid, the following definition must be fulfilled:-

Total and Permanent Disability means the complete inability of the Person Covered to engage in any occupation and to perform any work for remuneration or profit. Injury due solely and directly to violence occasioned accidentally by external and visible means and resulting in total and irrecoverable loss of the sight of one eye and the loss by physical separation of one limb at or above wrist or ankle will also constitute such total and permanent disability.

Section A

1. Are you the patient's usual Medical Attendant? Yes ☐ No ☐

   If yes, over what period do your records extend?

2. When were you first consulted for this condition and at that time how long had symptoms been present?

3. On which date the patient first became aware of the disease?

4. Date of last consultation / examination.

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5. Date when the patient first unable to attend work.

6. Are you currently issuing Medical Leave Certificates? If yes, for what period did you intend to renew them?

7. Please give details of the patient's habits in relation to cigarette smoking.

8. What is the nature and extent of the patient disability? Please provide us as much details as you can to describe of the disability.

9. Please give the precise diagnosis and provide us with the classification used (if available) to categories the severity of the disability.

10. Please describe the symptoms currently disabling the patient.

11. Had the patient previously suffered from this condition or any related illness?

12. Is the patient suffering from any other condition?
If yes, does this have an effect on the condition above?

13. Please describe the residual disability.

a) Recovered

b) Improved

c) No improvement

d) Deteriorating

e) Others, please specify

14. Are there any other circumstances that may have an effect on the patient's return to work?

15. Kindly provide us the details inpatient/ outpatient treatment with/surgery done for this patient.

Date	Diagnosis	Treatment/surgery	Prognosis	Details

16. Please give name and address of all Consultants, Specialists or Hospital to which the patient has been referred or attended for this condition

Name of Hospital	**Name of Consultant**

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17. Is the patient still receiving hospital care? Please give details if applicable.

18. Please comment on the patient's ability to perform the following

a) Capable of heavy manual duties (ie little restriction on mobility)

b) Capable of light manual duties (ie slight restriction on mobility)

c) Capable of sedentary duties (ie moderate restriction on mobility)

d) Incapable of sedentary duties (ie marked / severe restriction on mobility)

19. Are stress, emotional or psychological conditions relevant to the patient's condition?

☐ Yes ☐ No

If yes, please comment:

_____

_____

20. Do you anticipate that any psychological condition will permanently affect the patient's ability to resume employment?

☐ Yes ☐ No

If yes, please comment:

_____

_____

21. We would be grateful for your advice on the patient's ability to perform an occupation as follows:-

		Own Occupation	Other Occupation (including sedentary)
i)	Is the patient totally disabled from performing	_____	_____
ii)	Do you anticipate an improvement in the condition so as to enable a return to	_____	_____
iii)	If yes, when do you consider the patient will be able to resume work in	_____	_____

22. Is the patient currently undergoing any form of rehabilitation? ☐ Yes ☐ No

23. Please comment on any further treatment or rehabilitation which may improve the patient's condition eg retraining, physiotherapy . ***We would be grateful for copies of any relevant hospital reports which are available***

Section B

1. Please comment on the patient's ability to perform the following Activities Of Daily Living based on the Rating Guide below:

Rating Guide:

Score 1	Able without assistance, i.e. no help is needed
Score 2	Occasional help, i.e. need help less than 50% of the time
Score 3	More often than not, i.e. need help about 50-75% of the time
Score 4	Most of the time, i.e. need help 75-90% of the time
Score 5	Almost always/always, i.e. need help all the time or totally unable

Using the rating guide, please **CIRCLE THE SCORE** against each of the ADL's, which best describes the level of assistance the patient requires. We understand that for some people, ability to manage ADL's may vary from day to day and within the day. Therefore, the answers should indicate the level of assistance the patient requires on a typical day.

(a) **Transfer** - Getting in and out of a chair without requiring physical assistance.

Score : 1 2 3 4 5

Please describe any difficulties the patient has or any practical support or assistance the patient receives.

_____

_____

Please tell us if the patient is using any special or adapted equipment to help in transferring.

_____

_____

From what date did the patient need assistance (if applicable) with this activity?

_____

_____

(b) **Mobility** - The ability to move from room to room without requiring any physical/person assistance.

Score : 1 2 3 4 5

Please describe any difficulties the patient has or any practical/person support or assistance the patient receives.

_____

_____

Please tell us if the patient is using any equipment to help in getting around from room to room.

_____

_____

From what date did the patient need assistance (if applicable) with this activity?

_____

(c) **Continence** - The ability to voluntarily control bowel and bladder functions such as to maintain a satisfactory level of personal hygiene.

Score : 1 2 3 4 5

Please describe any difficulties the patient has or any practical/person support or assistance the patient receives.

_____

_____

Please tell us if the patient is using any equipment or protective garments due to difficulties with managing continence.

_____

_____

From what date did the patient need assistance (if applicable) with this activity?

_____

_____

(d) **Dressing** - Putting on and taking off all necessary items of clothing without requiring assistance of another person.

Score : 1 2 3 4 5

Please describe any difficulties the patient has or any practical support or assistance the patient receives.

_____

_____

Please tell us if the patient is using any equipment or special clothing to help with dressing.

_____

_____

From what date did the patient need assistance (if applicable) with this activity?

_____

(e) **Bathing / Washing** - The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.

Score : 1 2 3 4 5

Please describe any difficulties the patient has or any practical support or assistance the patient receives.

_____

_____

Please tell us if the patient is using any equipment to help with washing and/or getting in and out of the bath.

_____

_____

From what date did the patient need assistance (if applicable) with this activity?

_____

_____

(f) **Eating** - All tasks of getting food into the body once it has been prepared and made available.

Score : 1 2 3 4 5

Please describe any difficulties the patient has or any practical support or assistance the patient receives.

_____

_____

Please tell us if the patient is using any equipment to help with feeding.

_____

_____

From what date did the patient need assistance (if applicable) with this activity?

_____

_____

2. In your opinion, what was the root cause for the patient current disability?

3. Noted that the patient currently undergoing physiotherapy, please advise on the patient response to this treatment.

4. Will the patient fully recover after physiotherapy? If not, how long he need to continue with this treatment enable him to return to occupation?

5. Will the patient be able to perform other type of occupation (including sedentary)? Is not, please provide the reasons?

Totally And Permanently Disabled:

"that if the disability occurred on or after the attainment of age 15, the Participant or Person Covered (as is appropriate where applicable) at such disability date and at anytime thereafter, becomes completely unable to engage in any occupation and to perform any work remuneration or profit. The total and irrecoverable loss of both eyes or the loss of severance of two limbs at or above wrist or ankle, or the total and irrecoverable loss of sight of one eye and the loss by severance of one limb at or above wrist or ankle will also constitute such total and permanent disability"

6. Did the patient condition fulfill the above mentioned definition? If No, please provide your clarification

7. If there are further information which, in your opinion, will assist our Chief Medical Officer in assessing this claim, please give details

I hereby certify y that the above answers are all true and to be the best of my knowledge.
Saya dengan ini mengesahkan semua jawapan di atas adalah benar dan pada pengetahuan terbaik saya.

Name of Doctor :

Professional Qualification :

Signature :

Practice stamp and address :

Date :