AmMetLife Takaful Berhad (931074-V) Licensed Takaful Operator
Level 23, Menara 1 Sentrum, No. 201, Jalan Tun Sambanthan, 50470 Kuala Lumpur
1300 22 9777 +603 2272 3229 customercare@ammetlifetakaful.com
Type AMT<space>message send to 33911 ammetlifetakaful.com

AmMetLife Takaful

CONFIDENTIAL MEDICAL CERTIFICATE
TOTAL AND PERMANENT DISABILITY (TPD) BENEFITS CLAIM

Kindly answer all questions completely as this will assist us to assess the claim accurately, fairly and promptly. We appreciate your co-operation. The cost of this report is borne by the applicant.

A. GENERAL INFORMATION

1. Certificate No(s).

a. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ d. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ e. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ f. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. Participant Name* ☐

3. NRIC No.* ☐☐☐☐☐☐☐☐☐☐☐☐

(Old / Passport) ☐☐☐☐☐☐☐☐☐ (New) ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐

4. Age ☐☐ 5. Race ☐ 6. Occupation ☐

B. GENERAL INFORMATION

To be completed if disability is caused by an accident.

7. Date of Accident ☐☐ / ☐☐ / ☐☐☐☐ 8. Time ☐☐ : ☐☐ AM ☐ PM ☐

9. Place ☐

10. Type of Accident ☐

11. What was the nature and extent of the injury?

_____

12. When was the first time you attended to the patient?

_____

13. Was the patient under the influence of drugs / alcohol or other substance?

_____

To be completed if disability is caused by an illness.

14. What were the symptoms / signs / complaints and when was it first visible in the patient?

_____

15. Give details of investigations performed with dates & results.

_____

16. What was the diagnosis? Please provide full and exact details of the diagnosis.

_____

17. When was the diagnosis done and did you inform the patient of the diagnosis? If so when?

_____

18. How long has the patient suffered from the illness or from the related conditions?

_____

19. As of now, what are the treatments the patient is undergoing and details of further treatments required?

_____

20. Do you know of any illness or related conditions suffered by the patient? Please state the illness or the related conditions and when was the diagnosis done?

_____

* Mandatory / *Wajib*

21. Have you ever treated the patient for any other illnesses or related conditions? If yes, please give the details.

Date	Diagnosis	Treatment

22. From patient's record, who have attended to him / her (for any illness) prior to the disability?

Name & Address	Date	Complaints	Treatment

23. Is the patient being referred by any other doctor? If yes, please give the name and address of the doctor.

_____

C. PATIENT'S CURRENT CONDITION

24. Is the patient currently undergoing any recovery / rehabilitation process?

_____

25. Does the patient have any chance of recovery?

_____

26. Are you able to foresee any physiological condition which will affect the patient's ability to work again?

_____

27. Please provide any further information, be it a clinical one or otherwise, that will help us in processing this claim.

_____

28. When was the first time you attended to the patient? The last date of treatment:

_____

29. Please state the expected degree of recovery within the next 12 months.

_____

30. In your opinion, will the patient have an employment opportunity in accordance with his / her qualification, training and experience?

_____

31. Please state any activity or function that the patient is not able to perform as a result of his / her disability and, in particular, any of which if still being carried out, may eventually cause danger to other people?

_____

_____

_____

32. Please outline why you regard the patient as being unable to return to his / her occupation in either a part time or full time capacity.

_____

_____

_____

_____

_____

_____

33. Please state the physical and cognitive functions that will be totally lost as a result of the patient's disability:

Recovered ☐ Improved ☐ Not Changed ☐ Deteriorated ☐

34. How do you assess the patient's level of ability to undertake the following activities:

	Not Limited	Somewhat Limited	Moderately Limited	Very Limited	Unable to do it
Looking / sight	☐	☐	☐	☐	☐
Hearing / sound	☐	☐	☐	☐	☐
Judgment / Thinking / mental faculty	☐	☐	☐	☐	☐
Picking up & Carrying while standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Changing posture / Position	☐	☐	☐	☐	☐
Bowing	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Working by using both hands	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Putting on clothes	☐	☐	☐	☐	☐
Using toilet	☐	☐	☐	☐	☐
Reaching for / attaining above shoulder height	☐	☐	☐	☐	☐
Walking on an uneven surface	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

35. The patient's ability to use hands for a repeated action:

	Right Hand		Left Hand	
	Yes	No	Yes	No
Ordinary clenching	☐	☐	☐	☐
Complex manipulation	☐	☐	☐	☐
Circling / lower limb movement	☐	☐	☐	☐
Strong clenching	☐	☐	☐	☐
Pushing / pulling	☐	☐	☐	☐

I hereby certify that I have personally examined the above named Participant and that the injuries / disability stated above represent my medical opinion of his / her current condition.

_____

Medical Officer's signature

Name : _____

Tel Number : _____

Address : _____

_____ Official Stamp : _____

_____

Date : _____