

ATTENDING PHYSICIAN STATEMENT

TO:

Dear Doctor,
MEDICAL RECORD

Name : _____
NRIC No. _____ Certificate No. _____

The above name has a Family Takaful Certificate with our company and the
..... claim has been filed under the certificate.

It would be in the claimant's best interest if all material facts regarding his/her/deceased's health are fully stated in this form to enable us to assess the claim application. A consent letter duly signed by the claimant is enclosed for the release of the medical record available at your clinic. Kindly provide us with the following information by completing the format herein. If for any reason you do not wish to use this format, please feel free to provide us with the report on own stationery and kindly use this format as a guide for the information we require. The cost of the said report is to be borne by the Company.

We would appreciate an early reply for our immediate assessment of the claim.

Thank you.

Yours faithfully,
AmMetLife Takaful Berhad

If you do not have any records on the above Participant, please tick the box below and return this document to the above named Officer at our Head Office Address above.

I do not have any medical records of the above named

(Clinic Rubber Stamp)

Date

Doctor's Signature

Doctor's Name

1. GENERAL INFORMATION

(a) Name of Participant

(b) NRIC No.

(c) Admission/Ref No.

2. (a) Date the Participant first consulted you

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(b) Date you last saw him/her professionally

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3. Please state from past records or from your personal knowledge details of all illnesses, accidents, surgical operations or diseases from which the Participant has suffered or has been treated at your clinic.

Date	Complaints & Symptoms	Diagnosis Established	Treatment	Duration

4. Does the participant

Yes No

If 'YES' In What Form & Quantity

a. Smoke

<input type="checkbox"/>	<input type="checkbox"/>
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b. Drink alcohol

<input type="checkbox"/>	<input type="checkbox"/>
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c. Use narcotics

<input type="checkbox"/>	<input type="checkbox"/>
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5. Do you have any knowledge of participant having received advice, treatment or having investigations carried out by any other Doctor?

Yes No

Date of visit	Reasons for consultation	Name and address of physician consulted	Type of test done	Results of test done

6. We understand that the participant consulted on _____ for _____ as such we would be grateful if you could kindly provide us with information regarding this consultation/treatment. Kindly provide us with the information in this space or another sheet, if necessary.

7. Please use this space to provide us with any other additional comments that you feel may assist us to understand the participant's impairments or health status. (Please use additional sheet if necessary).

This report has been prepared by

Name of Doctor

Signature of Doctor: _____

Official Stamp

Date: _____

Telephone No.

Kindly return this form in a sealed envelope to the claims department of our company so as to maintain confidentiality of the information provided

(We thank you for completing this format)

Name of Officer: