ZURICH Takaful

Claim No. (For Office Use Only)										
1										
2										
3										
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6										

Total and Permanent Disability – Attending Physician's Statement

Instructions & Important Note:

- This form must be completed by the attending physician (who is a registered Medical Practitioner qualified and licensed to practice western medicine and who is practicing within the scope of his / her licensing / training) at the claimant's expense.
- The attending physician is required to tick (√) & complete the relevant part(s) below.
- If there is insufficient space, please use a separate sheet(s) of paper for your response.

Part A : Details of Patient (Person Covered)

1. Name		2. Gender	[ ] Male [ ] Female
3. New NRIC Number		4. Old IC No. / Passport No / Birth Certificate No.	
5. Age		6. Certificate Number	

Important: Please enclose copies of all reports including X-rays, CT scans, any other imaging studies, laboratory evidence, surgery report, visual acuity test report, hearing test report etc. and any relevant hospital reports that are available.

Part B : Details of Patient's Diagnosis

1 a Are you the patient's regular doctor? [ ] Yes [ ] No

b If Yes, since when? D D M M Y Y Y Y

2 a When were you first consulted for this disability? D D M M Y Y Y Y

b What were the symptoms / complaints? _____

_____

c Date of onset of symptoms / complaints D D M M Y Y Y Y

3 a Full and exact diagnosis / disability _____

_____

b When was the patient / patient's next of kin first informed of the diagnosis / disability? D D M M Y Y Y Y

c What was / were the underlying cause(s)? _____

_____

_____

4 Details of the current mental impairment of the patient (if any) _____

_____

_____

Note: Question 5 is compulsory to be completed if the disability was caused by an ACCIDENT.

5 a Date and time of accident

D	D	M	M	Y	Y	Y	Y

_____ am / pm

b Place of accident

_____

c Details of how the accident happened

_____

_____

_____

d Was the patient under the influence of alcohol / drugs at the time of the accident?

☐ Yes ☐ No

If "YES", please state the blood alcohol content / drug type and quantity consumed.

(i) Blood alcohol content: _____

(ii) Type of drug: _____

(iii) Quantity consumed: _____

6 Details of the investigation performed with dates and results
(If there is insufficient space, please use a separate sheet(s) of paper for your response.)

Date	Investigation Test	Result

7 Is the current diagnosis related to:

☐ Congenital
☐ Hereditary
☐ Due to Alcohol / Drugs
☐ Self-inflicted Injury
☐ Mental / Emotional / Sleeping Disorder
☐ Pregnancy / Childbirth / Miscarriage
☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ Human Immuno-deficiency Virus (HIV) Infection
☐ Traumatic Injury
☐ None of the above

8 To your knowledge, has the patient suffered from any of the following illness / condition?

	Yes	No	Date of Onset	Name of Doctor / Clinic / Hospital
a Hyperlipidemia				
b Hypertension				
c Diabetes Mellitus				

d Is this disability related to any other condition from which the patient has suffered in the past?

☐ Yes ☐ No

If "YES", please give details.

(i) Date of Diagnosis

D	D	M	M	Y	Y	Y	Y

(ii) Details of Diagnosis / Condition

(iii) Name of doctor / clinic / hospital who made the diagnosis

(iv) Treatment / Medication rendered

Part C : Details of Treatment

1 Details of current medication given:

a Name of medication

b Dosage

c Duration to be taken _____ (days / months / years)

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

If "YES", please give details.

3 Details of other treatment rendered (if any)

4 Can the patient's condition be further improved with physiotherapy / medication / surgery or any relevant treatment? ☐ Yes

If "YES", please give details.

☐ No

If "NO", please give the reason.

5 Has the patient achieved maximum medical improvement? ☐ Yes ☐ No

If so, please give details.

Part D : Neurological Examination Report

1 a Date when the patient's neurological impairments were first noted / onset

D	D	M	M	Y	Y	Y	Y

b Date of latest / current assessment

D	D	M	M	Y	Y	Y	Y

Note: Question 2 to 8 are compulsory to be completed based on the patient's latest / current condition.

2 Vision
(Visual Acuity Both Eye)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

3 Hearing
(For ENT Specialist Opinion, Audiometry)

	Right	Left
Normal		
Impaired		
Scores based on Speech Reception Threshold (dB)		

Remarks: _____

4 Function of speech

- ☐ Clear and understandable
- ☐ Slurred
- ☐ Unable to speak
- ☐ Others, please specify: _____

5 Cognitive function

- ☐ Normal
- ☐ Poor comprehension
- ☐ Difficult with logic and reasoning
- ☐ Memory loss
- ☐ Others, please specify: _____

6 General Inspection:

a Is there any abnormal movement?
(Please explain in detail, if any)

_____

_____

_____

b Is there any muscle wasting?
(Please explain in detail, if any)

_____

_____

_____

7 Examination of Limbs:

Please indicate the muscle power of each joint in the boxes provided. ***(Lowest score: 0; Highest score: 5)***

a Upper Limbs

	Right	Left
Shoulder	/ 5	/ 5
Elbow	/ 5	/ 5
Wrist	/ 5	/ 5
Grip	/ 5	/ 5

b Lower Limbs

	Right	Left
Hip	/ 5	/ 5
Knee	/ 5	/ 5
Ankle	/ 5	/ 5

Remarks: _____

8 Assessment for Activities of Daily Living:

	No Limitation	Limited But Capable	Completely Incapable
a **Transfer** (Getting in and out of a chair without requiring physical assistance)	☐	☐	☐
b **Mobility** (The ability to move from room to room without requiring any physical assistance)	☐	☐	☐
c **Continence** (The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene)	☐	☐	☐
d **Dressing** (Putting on and taking off all necessary items of clothing without requiring assistance of another person)	☐	☐	☐
e **Bathing** (The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other names)	☐	☐	☐
f **Eating** (All tasks of getting food into the body, once it has been prepared)	☐	☐	☐

9 What is the patient's prognosis with appropriate treatment and management for the next 12 months?

☐ Recovered
☐ Improving
☐ Progressively worsening

Remarks: _____

_____

_____

10 Is there full recovery expected or continuous improvement in the patient's condition?

☐ Yes

If ''YES'', please state an approximate period for full recovery from now.

_____

☐ No

If ''NO'', please state the extent of recovery expected and the time length.

_____

11 The patient's current state of mobility:

☐ Ambulatory
☐ Confined at home
☐ Confined at hospital
☐ Confined to bed
☐ Subject to some other restriction in movement or lifestyle?
If so, please give details.

_____

_____

Part E : Assessment of Patient's Disability

1 a Patient's occupation prior to disability

_____

_____

b Nature of duties of the occupation

_____

_____

2 When is the patient expected to return to his / her usual occupation?

D D M M Y Y Y Y

3 If the patient is unable to return to his / her usual occupation, is he / she able to engage in any other type of occupation?

☐ Yes ☐ No

(i) If "YES", what kind of occupation can he / she be engaged in?

_____

_____

(ii) If "YES", when is the patient expected to engage in these occupations?

D D M M Y Y Y Y

4 Does the patient's disability render him / her partially disabled or totally and permanently disabled?

Please tick in the appropriate column:

(i) Partially Disabled ☐ Yes ☐ No

(ii) Total and Permanently Disabled ☐ Yes ☐ No

If ''YES'', when did the patient certified to be **Total and Permanently Disabled**?

D D M M Y Y Y Y

5 Is the patient physically and / or mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

If "YES", when did such disability begin?

D D M M Y Y Y Y

6 If the incapacity of the patient 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 would be the tentative date of appointment?

D D M M Y Y Y Y

Part F : Additional Information For Juvenile Less Than 16 Years Old

1 Does the patient require constant care and attention? ☐ Yes ☐ No

2 Is the patient confined to home and under medical supervision? ☐ Yes ☐ No

3 Is the patient confined to hospital or other similar institution? ☐ Yes ☐ No

4 What was the treatment and care rendered to the patient during the confinement?

_____

_____

Part G : Patient's Medical Information

1. Please provide the name and address of all doctors, specialists, or hospitals to which the patient has been referred or attended for this condition.

Consultation date(s)	Name of Doctor	Name and Address of Clinic / Hospital

2. (a) Has the patient previously suffered from this disease or any related illness? ☐ Yes ☐ No

(b) If Yes, please state the dates of consultations, diagnosis, name of doctor, name of clinic / hospital and the treatments / medications given.

Consultation Date(s)	Diagnosis	Name of Doctor	Name of Clinic / Hospital	Treatment / Medication(s) Given

3. In your opinion, is there any further information that will assist us in assessing the claim. If Yes, please furnish such information below.

I hereby certify that I have personally examined and treated the patient for the above injuries / illness. I hereby declare that all the answers and statements are complete and true to the best of my knowledge, belief and that I have withheld no material fact from Zurich Takaful Malaysia Berhad. I also hereby certify that the above information is correct as per records from the hospital / clinic.

Signature of Attending Physician	Name & Qualification of Attending Physician	Official Stamp of Hospital
Date	**Email Address**	**Telephone No**
D D M M Y Y Y Y		