CONFIDENTIAL

eTiQa Takaful

Statement To The Medical Examiner (Adult) PRIVATE & CONFIDENTIAL

You are required to disclose fully and faithfully all the relevant information which you know or ought to know otherwise it may lead to the Certificate issued hereunder being set aside, your claim being refused or the terms of the Certificate being changed in compliance with Islamic Financial Services Act 2013.

Name of Agent and Code.: ______________________________________ Proposal No.: [ ]

A. PERSONAL DETAILS

1. Name of Applicant (Capital Letter)

2. NRIC No.

3. Date of Birth — Date Month Year

4. Age — Year Month

5. Sex — Male / Female

6. Occupational (including part-time)

____

7. Amount Covered — RM

8. Name & Address of your personal doctor that you frequent most:

____

9. Date when last consulted doctor and reason.

____

10. At present, are you on any form of medication? [ ] Yes [ ] No (if yes, please state reason and type of medication)

____

11. Have you at any time consulted a psychiatrist? [ ] Yes [ ] No (if yes, please give details and date)

____

B. HEALTH DETAILS

				DETAILS of "Yes" answer.
1	Have you EVER had or been told you had or been treated for			*Kindly include diagnosis, dates, results, duration, names and address(s) of all attending doctors and medical facilities.*
	a. Epilepsy, fainting spells, seizure, nervous or mental condition, neuritis, paralysis or any disease or abnormality of the brain or nervous system?	[ ] Yes	[ ] No	
	b. Giddiness, loss of consciousness, chest pain, high blood pressure, palpitation or any disease of the heart, blood or blood vessel?	[ ] Yes	[ ] No	
	c. Blood spitting, tuberculosis, asthma, habitual cough, pleurisy or any respiratory or lung disease?	[ ] Yes	[ ] No	
	d. Recurrent indigestion, ulcer, hernia or disease of liver, gall bladder, stomach or intestine?	[ ] Yes	[ ] No	
	e. Urinary sugar/albumin, stones, venereal disease, menstrual disorders or diseases of the kidney, prostate, urinary or genital system?	[ ] Yes	[ ] No	
	f. Diabetes, goiter or any disease or abnormality of the thyroid or other endocrine glands?	[ ] Yes	[ ] No	
	g. Diseases of eyes, ears, nose (including nose bleeds) or throat?	[ ] Yes	[ ] No	
	h. Cancer, tumor, cyst or any growth?	[ ] Yes	[ ] No	
	i. Jaundice, hepatitis, any disease of the liver or been a hepatitis carrier?	[ ] Yes	[ ] No	
	j. Malaria, dysentery or any tropical diseases?	[ ] Yes	[ ] No	
	k. Rheumatic fever, arthritis, gout or any disease of the spine (inclusive of prolapsed intervertebral disc), bone, joint, muscle, connective tissue, lymph nodes or any diseases of the skin?	[ ] Yes	[ ] No	

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B. HEALTH DETAILS

DETAILS of "Yes" answer.

Kindly include diagnosis, dates, results, duration, names and address(s) of all attending doctors and medical facilities.

2 Have you ever
Received any medical advice, counselling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition, or been told you had any of these or that you had HIV testing done (please state result) OR in the last 3 months had any of the following symptoms for more than one week continuously:
Fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?
☐ Yes ☐ No

3 In the past 5 years, have you had any:
a. Diagnostic test such as X-ray, mammogram, electrocardiogram, CT scanning, echo or ultra sonogram, blood or urine studies? ☐ Yes ☐ No
b. Illness, injury, operation, medical advice, hospital treatment or physical check-up not mentioned above? ☐ Yes ☐ No

4
a. Do you smoke? If so, what type, quantity and duration. ☐ Yes ☐ No
b. Do you drink beer, wine or spirits? If so, in what form and quantity? ☐ Yes ☐ No
c. Have you ever used habit forming drugs or narcotics or been treated for alcoholism or drug habit? ☐ Yes ☐ No
d. Do you any other physical defects or health impairments? ☐ Yes ☐ No

5
a. To the best of your knowledge and belief, has any of your immediate family ever had or died from asthma, tuberculosis, diabetes, heart disease, hypertension, mental disease, kidney disease or any other hereditary disease? ☐ Yes ☐ No
b. Has your spouse suffered from any AIDS related condition or been tested HIV positive? ☐ Yes ☐ No
c.

Family Record	Age if Living	Cause of Death	Age of Death
Father			
Mother			

6
a. Has your weight changed more than 5kg in the past year? If so, why? ☐ Yes ☐ No
b. Has any proposal for coverage on your life ever been declined, withdrawn, postponed, rated, reinstated or modified in any way? ☐ Yes ☐ No

7 FEMALE Only
a. Have you ever had any disease of the breast or female organs or complications at child birth? ☐ Yes ☐ No
b. Are you now pregnant? If Yes, how many months? _____ mths ☐ Yes ☐ No

C. DECLARATION AND CONSENT

I confirm that the above answers given by me are full, complete and true and agree that they form part of any certificate, where these answers are, or may be relied upon by the Company.

I, having read and understood the contents here of, hereby authorize ETIQA FAMILY TAKAFUL BERHAD, any of its appointed medical examiners or designated laboratories to conduct or perform blood and /or urine tests as may be necessary to underwrite my application for takaful coverage. These may include, but are not limited to, tests for cholesterol and related blood test, diabetes, liver or kidney disorders, infections by AIDS virus, immune disorders or the presence of medication, drugs, nicotine or their metabolites.

Provide that, unless my prior consent has been obtained, ETIQA FAMILY TAKAFUL BERHAD shall at all times, keep all results of any such tests confidential and use there of shall only be for the purposes of my application or further application for takaful coverage with ETIQA FAMILY TAKAFUL BERHAD except to such an extent that disclosure is required by any proper Government authority or by Law.

_____
Signature of Proposer

Date : _____

_____
Witnessed by (Medical Examiner)

Name: _____
NRIC: _____
Date: _____

Medical Examiner's Confidential Report
(To be Completed by Medical Examiner)

MEDICAL REPORT **PRIVATE & CONFIDENTIAL**

IMPORTANCE NOTE: This examination should be made in private; no third person should be present.

D. PHYSICAL EXAMINATION

For Males Only

1. Height	2. Weight	3. Chest *(force expiration)*	4. Chest *(force inspiration)*	5. Abdomen *(at umbilicus)*
cm	kg	cm	cm	cm

Visual acuity

	6. Right eye	7. Left eye	8. Funduscopy
Uncorrected			
Corrected			

E. HEALTH DETAILS

DETAILS of "Yes" answer.

If any answer is "Yes" kindly provide full details of adverse findings and opinions

1. Have you ever seen the applicant professionally before? ☐ Yes ☐ No
   If "Yes" we would appreciate if you would review your records to confirm that all items of the proposed life's physical history have been declared overleaf. If not, please give details of any omissions or inaccuracies.

2. Are you in any way related to the Proposed Life? ☐ Yes ☐ No

3.
   a. Is there any evidence of ulcers, hernia, piles, fistula or varicose veins? ☐ Yes ☐ No
   b. Does appearance indicate poor health? ☐ Yes ☐ No
   c. Does he/she appear older than stated age? ☐ Yes ☐ No
   d. Is there any reason to suspect intemperate habit? ☐ Yes ☐ No

4. Do you find any evidence of past or present disease or abnormality of:
   a. Respiratory system (lungs, pleura, chest wall)? ☐ Yes ☐ No
   b. Central or peripheral nervous system (including reflexes, gait, paralysis)? ☐ Yes ☐ No
   c. Genito - urinary system? ☐ Yes ☐ No
   d. Gastrointestinal system (including hernias)? ☐ Yes ☐ No
   e. Breasts, skin, bones or joints including varicose veins, deformities, lameness, amputations, scars/identifying marks)? ☐ Yes ☐ No
   f. Eyes, ears, nose, throat and mouth (including impairment of sight or hearing)? ☐ Yes ☐ No
   g. Thyroid or other endocrine glands or metabolic and hemopoietic systems? ☐ Yes ☐ No
   h. Lymphatic system? ☐ Yes ☐ No

5.

URINALYSIS **N.B.:** **Trace amount must be noted**	**Blood**	**Sugar**	**Albumin**	**Specific Gravity in units**

Send specimen for microscopic urinalysis if:
i. Blood pressure is over 140/90
ii. Albumin, blood or sugar is present
iii. Family history of diabetes
iv. There are any findings of history of urinary disease
v. Applicant is a diabetic or under treatment for blood pressure

For female proposer, to indicate LMP when blood is present.

Is blood specimen sent for analysis? Yes / No If Yes, which profile? _____

6. BLOOD PRESSURE
(if over 140 systolic or 90 diastolic or with history of hypertension, record 3 readings at an interval of 5 minutes)

Systolic	mmHg	mmHg	mmHg
Diastolic (5th phase)	mmHg	mmHg	mmHg

E. HEALTH DETAILS

DETAILS of "Yes" answer.

If any answer is "Yes" kindly provide full details of adverse findings and opinions

7 **Pulse**

Peripheral Pulses : _____

(If pulse is irregular or pulse > 90 or < 50 min, record 3 readings)

	At Rest	After Exercise	3 Minutes Later
Rate per minute			
Irregularities per min			

8 Heart

Apex beat located in _____ intercostal space _____ cm to the (☐ right ☐ left)
of the Midsternal line.

a. Is the heart enlarged? ☐ Yes ☐ No

b. Is there any:
   i. Arteriosclerosis or aneurysm? ☐ Yes ☐ No
   ii. Hypertrophy or oedema? ☐ Yes ☐ No
   iii. Murmur (if murmur is present, describe below) ☐ Yes ☐ No

Location:	☐	Parasternal	☐	Apex	☐	Aortic are	☐	Base	☐	Pulmonary area
Timing:	☐	Systolic	☐	Diastolic	☐	Presystolic	☐	Pansystolic	☐	
Intensity:	☐	Soft	☐	Moderate	☐	Loud	☐		☐	
Transmission:	☐	None	☐	Axilla	☐	Scapula	☐		☐	
After exercise:	☐	Absent	☐	Increased	☐	Decreased	☐	Unchanged	☐	

Diagnosis: _____

c. Is there excessive dyspnea after exercise? ☐ Yes ☐ No

d. Do you suspect any abnormality in the heart or vascular system upon review of your overall findings? ☐ Yes ☐ No
   If so, why? _____

9 a. Are you aware of any unfavorable features likely to affect his/her longevity
   i. In the personal or family history? ☐ Yes ☐ No
   ii. Disclosed in your medical examination? ☐ Yes ☐ No

b. Do you recommend any additional tests or reports? ☐ Yes ☐ No

c. Do you know any facts about this risk not brought out earlier? ☐ Yes ☐ No

d. What is your general impression of the applicant after completing your medical examination? ☐ Yes ☐ No
   _____

10 Do you have any reason to believe that the applicant is a higher than average risk for AIDS? If so, why? ☐ Yes ☐ No
_____

F. DECLARATION

I certify that I have personally verified the identity of the Proposer whom I have examined. This examination has been conducted in private at:
Clinic Name & Address: _____

_____
Signature of Examiner
Name :
NRIC No:
Date:
Clinic Rubber Stamp