



TAKAFUL IKHLAS SDN BHD (593075 u)
Family Claims Department
4th floor, Bangunan Takaful Ikhlas
No 14, Jalan 19/1
47300 Petaling Jaya Selangor
(A subsidiary of Malaysian National Reinsurance Berhad)

CORONARY ARTERY BYPASS SURGERY/BALLOON ANGIOPLASTY
(to be completed by the doctor)

Name: _____

I/C No: _____

Certificate No: _____

The above named has a coverage with Takaful Ikhlas Sdn Bhd against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with a Coronary Artery Bypass Surgery/Balloon Angioplasty and to enable us to asses the claim, we would appreciate it if you could complete this confidential report and return it direct to us at the following address:-

TAKAFUL IKHLAS SDN BHD (593075 u)
Family Claims Department
Ground floor, Bangunan Takaful Ikhlas
No 14, Jalan 19/1
47300 Petaling Jaya Selangor

In order for the claim to be valid the illness/ procedure performed must be fulfilled the Critical Illness definition as stated in the certificate contract.

Please tick [x] the type of illness/ procedure performed, which is applicable.

- Coronary Artery Disease Requiring Surgery (Coronary Artery By-Pass Surgery)
- Coronary Artherectomy (Balloon Angioplasty)
- Heart Valve Replacement
- Aorta Surgery
- Others _____

Coronary Artery Bypass Surgery Balloon Angioplasty

1) General

- i) Are you the participant's usual medical attendant? If yes, over what period do your records extend?

- ii) When were you first consulted on the patient's heart disease and, at that time, how long had symptoms been present?

- iii) Has the participant previously suffered from the condition specified above or any other illness? e.g. hypertension, diabetes, angina or other vascular diseases. If yes, please give the duration of the illness, dates of consultations and the resulting diagnosis.

- iv) On which date did the participant first become aware of the disease?

- v) Is there anything in the participant's family history which would have increased the risk of a heart disease/attack?

- vi) Please give details of the participant's habits in relation to cigarette smoking.

- vii) Was the participant referred to you? If so, please give the name and address of the referring doctor/Medical Practitioner.

Coronary Artery Bypass Surgery Balloon Angioplasty

2. Details of procedure performed.

i) Date of procedure performed.

ii) Please give details of the illness/procedure perform (i.e: CABG, surgery, angioplasty) by attaching a copy of the operation/procedure notes.

iii) Please provide the full address of any hospitals to which the participant was referred together with names of the consultant attended.

We would be grateful for copies of any relevant hospital reports that are available.

3. If there is any further information which, in your opinion, will assist us in assessing this claim, please furnish such information below:-

Signature_____

Name _____

Clinic _____

Qualification _____

Date _____

Telephone No._____