



**TAKAFUL IKHLAS SDN BHD** ( 593075 U)  
Family Claims Department  
4<sup>th</sup> Floor, Wisma KT  
No 14, Jalan 19/1  
46300 Petaling Jaya, Selangor

**KIDNEY FAILURE**  
(to be completed by doctor)

Patient Name: \_\_\_\_\_

I/C No.: \_\_\_\_\_

Certificate No.: \_\_\_\_\_

The above named has a coverage with Takaful Ikhlas Sdn Bhd against happening of certain contingent events associated with his/her health. A claim has been submitted in connection with a Kidney Failure and, to enable us to assess 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  
46300 Petaling Jaya, Selangor

In order for the claim to be valid the following definition must be fulfilled.

**KIDNEY FAILURE.** End stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is instituted or renal transplantation is carried out

## Kidney Failure

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1) General

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

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ii) What underlying kidney disease causing renal failure?

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iii) When were you first consulted for this disease and, at that time, how long had symptoms been present?

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iv) Has the participant previously suffered from renal disease or any related illness e.g. diabetes. If yes, please give dates of consultations and the resulting diagnosis.

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

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vi) Is there anything in the participant's family history which would have increased the risk of renal disease?

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

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2. Details of the participant's illness

	<u>Yes</u>	<u>No</u>
i) Is the participant's renal disease reached end stage	[ ]	[ ]
ii) Is the participant currently undergoing regular peritoneal or haemodialysis?	[ ]	[ ]
iii) Has renal transplantation been performed?	[ ]	[ ]

Kidney Failure

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- iv) Please provide the full address of any hospital to which the participant has been referred together with the names of the consultants attended.

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

- v) Please give names and addresses of any other medical practitioner who to your knowledge attended to the participant during the past three years?

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

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Signature \_\_\_\_\_ Hospital/Clinic Official Stamp:

Name of Doctor \_\_\_\_\_

Qualification \_\_\_\_\_

Date \_\_\_\_\_