



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

STROKE
(to be completed by doctor)

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

STROKE. This is defined as any cerebrovascular incident producing neurological sequelae lasting more than twenty four (24) hours and including infarction of brain tissue, hemorrhage or embolisation from an extra cranial source with evidence of permanent neurophysical deficit.

1. General

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

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

iii) Has the participant previously suffered from the condition specified above or any related illness? e.g. hypertension, transient ischemic attack, angina or other vascular disease. If yes, please give dates of consultation 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 stroke?.

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

2. Details of the participant's illness:-

i) Please provide full and exact details of the diagnosis.

- ii) Please describe the initial episode:-
- a) Nature of episode.

 - b) Date: _____
 - c) Duration of acute symptoms.

 - d) Date of return to normal activities and/or the participant's present limitations-physical and mental.

- iii) a) Please comment on any neurological sequelae which lasted more than 24 hours.

- b) Are these sequelae permanent?

- iv) Has there been an infarction of brain tissue, hemorrhage or embolisation from an extra cranial source?

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

- vi) Please supply details of radiological, CT scanning or NM imaging and laboratory evidence as well as any other tests.

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

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

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

Signature_____

Name _____

Clinic _____

Qualification _____

Date _____

Telephone No._____