TAKAFUL IKHLAS FAMILY BERHAD (593075-U)
(Formerly Known As Takaful Ikhlas Berhad)
IKHLAS Point, Tower 11A, Avenue 5, Bangsar South,
No.8, Jalan Kerinchi, 59200 Kuala Lumpur.
Tel : 03 2723 9999 Fax: 03 27118280
Website : www.takaful-ikhlas.com.my

ENCEPHALITIS OR BACTERIAL MENINGITIS
(to be completed by the doctor)

Patient Name : _____

I/C No : _____

Certificate No : _____

The above named has a coverage with Takaful Ikhlas Family Berhad against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with a Encephalitis Bacterial or Meningitis 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 FAMILY BERHAD (593075-U)
(Formerly Known As Takaful Ikhlas Berhad)
Family Claims Department
Ikhlas Point, Menara 11A, Avenue 5
Bangsar South, No 8, Jalan Kerinchi
59200 Kuala Lumpur

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

A) ***Encephalitis – resulting in permanent inability to perform Activities of Daily Living***

Severe inflammation of brain substance, resulting in permanent functional impairment. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of thirty (30) days applies. The covered event must be certified by a neurologist.
Encephalitis in the presence of HIV infection is not covered.

B) ***Bacterial Meningitis - resulting in permanent inability to perform Activities of Daily Living***

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent functional impairment. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of thirty (30) days applies.
The diagnosis must be confirmed by:
(i) an appropriate specialist; and
(ii) the presence of bacterial infection in the cerebrospinal fluid by lumbar puncture.
For the above definition, other forms of meningitis, including viral meningitis are not covered.

1) General

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

_____

_____

(ii) a) When were you first consulted for this disease?

_____

b) 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, transient ischemic attack, angina or other vascular diseases. If yes, please give dates of consultations and the resulting diagnosis.

_____

_____

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

_____

2. Details of the participant's illness:-

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

_____

(ii) Please describe the following:-

a) Duration of acute symptoms

_____

b) Date of return to normal activities or

_____

c) The participant's present limitations (latest report)-physical and mental (please provide details of neurological examination including Grade of muscle power of affected limbs, if relevant)

_____

_____

_____

_____

_____

d) Please provide details of the participant's permanent neurological deficit, if any.

_____

_____

f) Please mark (x) for "Activities of Daily Living" which is inability to perform by the participant:

a) [ ] Transfer – Getting in and out of a chair without requiring physical assistance
b) [ ] Mobility – The ability to move form 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/ Washing - The ability to wash in the bath or shower (including getting in and out of the bath of shower) or wash by any other means.
f) [ ] Eating– All tasks of getting food into the body once it has been prepared.

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

_____
_____

(iv) 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.

(v) Please give names and addresses of any other medical practioners 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 _____ Clinic / Hospital _____

Doctor Name _____ Telephone No _____

Qualification _____ Date _____

Official stamp: