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 2723 9998
Website : www.takaful-ikhlas.com.my

HEART DISEASE

(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 Heart Disease 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 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 related to Heart Disease, which is applicable:-

[ ] Coronary Artery Disease Requiring Surgery (Coronary Artery By-Pass Surgery)
[ ] Coronary Artherectomy (Balloon Angioplasty, Atherectomy, Laser Treatment or Insertion of Stent)
[ ] Heart Valve Surgery
[ ] Heart Attack –of specified severity
[ ] Surgery of Aorta
[ ] Primary Pulmonary Arterial Hypertension
[ ] Cardiomyopathy –of specified severity
[ ] Others : _____

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 by the patient and, at that time, how long had symptoms been present?

_____

iii) Give full and exact details of the diagnosis.

_____

iv) Has the participant previously suffered from the condition specified above or any other illness? i.e. hypertension, diabetes, Ischemic Heart disease or other vascular diseases. If yes, please give the duration of the illness, dates of consultations and the resulting diagnosis.

a) Diagnosis: _____

b) Duration of the illness: _____

c) First date consultation:_____

d) Medication : _____

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

_____

_____

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

_____

_____

2. Details of the participant's illness:-

i) Did the participant have:-	Yes	No
a) A history of typical prolonged chest pain	[ ]	[ ]
b) New electrocardiographic changes (ECG) resulting from this occurrence	[ ]	[ ]
a) Elevation of the cardiac enzyme (CPK-MB) above the generally accepted laboratory levels of normal	[ ]	[ ]

Important note: Please provide us with a copy of the report for the above findings.

ii) Is the participant in heart failure? If yes which class failure (NYHA classification)?

_____

3. Was any procedure performed? **Yes / No**

   i) If yes, please give the exact dated the procedure was performed.

   _____

   ii) Please give details of the illness/procedure perform (i.e: CABG, surgery, angioplasty).

   _____
   _____

   Please attached the angiographic evidence to confirm the location of stenosis and the operation.

   iii) What was the indication for the procedure performed? If angioplasty or stent was done please indicate the vessels involved and the percentage of blockage.

   _____
   _____

   Important note: For question (ii & iii) please attached the angiographic evidence to confirm the location of stenosis and the operation done.

   iv) Please give results of any investigations performed e.g. resting, ECGs, exercise stress test, enzyme assays, isotope imaging, coronary and LV angiography.

   _____
   _____
   _____

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

   _____
   _____

Signature _____Clinic / Hospital _____

Doctor Name _____Telephone No _____

Qualification _____ Date _____

Official stamp: