Medical Certification

To be completed by Registered Medical Practitioner only
(Not required for claim less than RM500)

TOKIO MARINE
INSURANCE GROUP

1) Patient Name : _____

NRIC/Passport/ID No. _____ Age: ___

2) Admission Date: ___ ___ ___ ___ (D D M M Y Y Y Y) Time: ___ ___ ___ ___ (M M H H) ☐ AM ☐ PM

3) Discharge Date: ___ ___ ___ ___ (D D M M Y Y Y Y) Time: ___ ___ ___ ___ (M M H H) ☐ AM ☐ PM

4. Name and Address of doctors previously consulted by the patient for the condition:

_____

5. Was this patient referred to you? If yes, please provide details of party who referred the patient to you.

_____

6. Is the injury consistent with the nature of accident as related to you by the patient?

_____

7. Describe in detail nature of illness / injury and your diagnosis of the patient's condition.

_____

8. Were there any external and visible injuries seen as a result of this accident?

_____

9. Are the patient's injuries due solely to this accident? ☐ Yes ☐ No

10. Give details of any circumstances, such as intoxication, physical defects or medical condition which may have contributed to the accident and/or prolonged the disability.

_____

11. Did the injuries require any of the following:

a. Surgery ☐ Yes ☐ No
b. X-ray / MRI ☐ Yes ☐ No
c. Follow-up ☐ Yes ☐ No

Type of surgery performed: _____
(Please enclose a copy of the X-ray / MRI report)
Type of treatment: _____

12. How long has the patient been disabled from engaging in or attending to his usual employment or occupation as a result of these injuries?

Totally : _____days From ___ ___ ___ ___ ___ ___ ___ ___ (D D M M Y Y Y Y) to ___ ___ ___ ___ ___ ___ ___ ___ (D D M M Y Y Y Y)

Partially : _____days From ___ ___ ___ ___ ___ ___ ___ ___ (D D M M Y Y Y Y) to ___ ___ ___ ___ ___ ___ ___ ___ (D D M M Y Y Y Y)

TOTAL DISABLEMENT arises when the Claimant is rendered completely incapable of attending to any part of his/her ordinary profession, business or vocation.

PARTIAL DISABLEMENT arises when the Claimant is capable of attending to some portion of his/her ordinary profession, business or vocation.

13. Current health status of patient's injury

a. Date the patient last consulted you:

b. Is the patient's disability? ☐ Progressive ☐ Stationary ☐ Improving ☐ Recovered

c. Is full recovery expected?

☐ Yes, please state approximate date D D M M Y Y Y Y

☐ No, please state the extent of recovery and approximate date. If the condition is irrecoverable and falls under permanently disablement, please give the **percentage (%) of the disability.**

d. Is the patient's injuries result in him/her permanently bedridden or permanent total disablement which render him/her from being gainfully employed of any and every kind? ☐ Yes ☐No

If Yes, please elaborate: _____

e. Does the patient have full power of all limbs? ☐ Yes ☐No

If No, please specify which limb(s) that does not have full power and the current power of the limbs

_____

14. Kindly provide us with additional information, if any, to further assist us in assessing this claim:

_____

_____

I hereby certify that I have personally examined and treated the Claimant for his/her injuries described above and that the facts as stated above represent my medical opinion of his/her condition.

_____ _____

Signature of Attending Physician: Date

Full Name : _____

Qualification(s) _____

Name of Hospital/Clinic _____

Address _____

Telephone No. _____