GENERAL MEDICAL QUESTIONNAIRE *(For completion by the Covered Participant)*

Note: This questionnaire forms part of your application for Takaful proposal. You are required to disclose in this questionnaire, fully and faithfully all the facts that you know or ought to know, otherwise the Certificate(s) issued under this application may be null and void.

Full name of the Covered Participant: _____

NRIC No. : _____ Certificate No. : _____

1. What was the specific reason/ complaint/ symptom that brought you to seek medical attention? How long had you been having this before seeing a medical attendant?

2. Which clinic/ hospital/ laboratory did you visit for Question 1?

3. Was there any investigation done? If yes, please specify all the investigations performed, including dates and their results.

4. What and when was the actual diagnosis/ comment/ abnormality mentioned by the medical attendants?

5. Was there any treatment given? If yes, please answer the following according to the treatment given.

   a. Hospital Admission. Please specify the reason, hospital, date of admission and duration.

   b. Operation. Please specify the type and date of operation performed and which part of the body was involved.

   c. Medication (including injection). Please specify the type/name of medication given.

   d. Others (which cannot be classified under any of above.) Please specify.

6. Is follow-up required (including post-operative follow-up)? If yes, please specify which doctor/ clinic/ hospital you have been following-up with and its intervals (monthly, quarterly, etc...)

7. Is there any treatment required after operation/ initial treatment? If yes please specify on what type of treatment is needed and its frequency.

8. If the follow-up was stopped, when was the last follow-up?

9. Has there been any recurrence? If Yes, please give details on the symptoms, when and action taken.

10. If there is more than one recurrence? Please specify the frequency and when was the last time you had the attack.

11. Have steroid drugs been prescribed? If yes, please specify the name of the medication, its dosage and frequency.

12. Is there any residual impairment/ incapacity/ complication after initial treatment or follow-up? If Yes, please specify.

13. When do you return to your full-time continuous work?

14. What was the total period of incapacity and to what extent your incapacity and restriction affected your daily activities?

15. Do you hold any medical report(s)? If yes, please submit a copy to us.

16. Any other information that you would like to inform us?

DECLARATION AND AUTHORIZATIONS

I declare that the above answers are true to the best of my knowledge and that I have not withheld any material information that may influence the assessment or acceptance of this proposal.

I agree that this supplementary questionnaire shall form part of my application for Takaful coverage with FWD Takaful Berhad and that failure to disclose any material fact known to me may invalidate the contract of takaful.

_____

Signature of Covered Participant

I/C No:

Date: