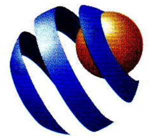
TOKIO MARINE
INSURANS (MALAYSIA) BERHAD (Co. No. 149520-U)



TOKIO MARINE

MEDICAL CERTIFICATION

In order to establish his/her Claim, the Claimant must obtain and forward to the Company a Certificate from a duly qualified and registered Medical Practitioner, and it is essential that this Form be filled up as minutely as possible so that the Officers of the Company may properly understand the nature of the case.

1. a) Name of Patient :.. Age ....

   b) Address ....

   ....

   c) Patient Ref. No. .... IC NO: .... Occupation: ....

2. a) Name & Address of Referral Doctor: (Please enclose copy of the referral letter) b) Date of Referral:	a) b)
3. a) Date & Time of Accident b) When and where first seen after the accident?	a) Date: Time: b)
4. a) Describe in detail the nature of accident as related to you by the patient. b) Is the injury consistent with the nature of accident as related to you by the patient?	a) b)
5. Describe in detail nature of illness / injury and your diagnosis of the patient's condition.	
6. a) Were there any external and visible injuries seen as a result of this accident? b) If yes, describe the extent of injuries including site and other characteristic features as seen by you.	a) Yes No b)
7. Are the patient's symptoms: a) Due solely to this accident or b) Traceable to disease, infirmity or any other cause? Please provide full details.	a) b)
8. Is the patient now or at the time of the accident sufferring from any illness, disease or infirmity? If so, state the nature and to what extent the recovery has been or may be retarded thereby.	
9. Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident? Please provide full details.	

10. Treatments given including follow-up (such as number of stitches, physiotherapy, type of dressing, etc.)

Date(s)	Time (am/pm)	Treatments

Stitches were removed on: ____________________________

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11. Name and address of other physician who treated patient for the same injury:

Date(s) | Address | Approximate duties

12. Did the injuries require any of the following:

a) Hospitalisation ☐ Yes ☐ No Date admitted: ________ Date discharged: ________
Date admitted: ________ Date discharged: ________

b) Surgery ☐ Yes ☐ No Type of surgery performed: ________

c) X-ray / MRI ☐ Yes ☐ No Please enclose a copy of the X-ray / MRI report

13. To what extent the injuries have necessarily disabled the patient from following his/her occupation or giving attention to Business? (All original medical sick leave &/or light duty certificates must be attached for weekly benefit claim).

Patient has been disabled Totally for .... days From .... To ....

Partially for .... days From .... To ....

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 Claiman is capable of attending to some portion of his/her ordinary profession, business or vocation.

14. a) Is the patient currently sufferring from any permanent total / permanent partial disablement (loss of use/function) due to the accident? ☐ No. ☐ Yes, 100% Permanent Total Disablement/Total Loss of Use

Yes, Permanent Partial Disablement at ________ % Date of the assessment: ________

b) If yes, please also provide the date of the onset of the Permanent Disablement: ________

c) Detailed description of the Permanent Disablement: ________

____

____

____

d) Date of patient's last visit: ________ e) Date of Next Follow-up, if any: ________

15. REMARKS:

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.

Name: ________

Qualification: ________ Signature: ________

Tel. No: ________ Date: ________

____
Hospital/Clinic Stamp