APPLICATION FOR

Dread Disease Benefit Statement by Medical Examiner

EMPLOYER TO COMPLETE THIS FORM
HAND TO MEMBER FOR FURTHER COMPLETION BY MEDICAL EXAMINER

METROPOLITAN LIFE KENYA

FUND NAME:

EMPLOYER NAME:

EMPLOYER BRANCH NAME OR NO: FUND NO:

1. Employee's details

Surname and title: Member ref. no:

First name and intials: Wage/paysheet no:

ID no.: Date of birth: D D M M Y Y Y Y

Residential address:

Postal code:

2. Dread disease details

This section to be completed by a medical examiner in support of a dread disease claim, provided for in terms of the rules of the fund. NOTE: Please supply copies of all specialist reports, enzymes, ECGs, etc.

1. Please confirm that the employee, has beenphotographically identified. YES NO
   If NO - state reasons.

   The following proof of identity has been presented:

   - ID
   - Passport
   - Other

2. Are you the employee's regular doctor? YES NO If YES, indicate for how long?
   If NO, state the name and address of the employee's regular doctor:

3. What illness/impairment has led to this claim?

   - Heart attack
   - Coronary artery surgery
   - Stroke
   - Cancer
   - Renal failure
   - Paraplegia
   - Major organ transplant
   - Blindness

4. Has the member...

   4.1 Had a **HEART ATTACK** (myocardial infraction)?

   An irreversible ischaemic myocardial infarction manifested by typical chest pain and equivalent symptoms, electrocardiographic change and significant cardiac enzyme elevation. YES NO

   If YES, please state
   The date of the infraction: D D M M Y Y Y Y

   How it was diagnosed:

18116 (V03'13) LF

Whether there were any other contributing factors/illnesses, and the nature, thereof:

Date of diagnosis

	DDMMYYYY
	DDMMYYYY
	DDMMYYYY
	DDMMYYYY

4.2 Had **CORONARY ARTERY SURGERY?**

An open surgical correction of narrowing or blockage of at least two coronary arteries with bypass grafts was performed with significant main stem or multiple coronary artery disease **but specifically excluding non-surgical techniques such as balloon angioplasty or laser relief of obstruction and prophylactic surgery.**

If YES, please state:

The date of the operation: DDMMYYYY

The date on which coronary artery disease was diagnosed: DDMMYYYY

Any other risk factors (eg. hypertension) present before the diagnosis:

Date of diagnosis

	DDMMYYYY
	DDMMYYYY
	DDMMYYYY
	DDMMYYYY

What surgical procedures were done?

What were the events predisposing to surgery and indications for surgery?

4.3 Had a **STROKE?**

The employee suffered cerebrovascular incident (including infarction of brain tissue, intra cranial or sub-arachnoid haemorrhage or embolism from an extracranial source) which resulted in permanent neurological dysfunction, **excluding cerebral damage directly resulting from an accident or violent external cause.**

YES ☐ NO ☐

If YES, please state:

The date of the incident: DDMMYYYY

How it was diagnosed:

Any contributing factors/illnesses, and the nature thereof:

Date of diagnosis

	DDMMYYYY
	DDMMYYYY
	DDMMYYYY
	DDMMYYYY

What was the specific type of cerebrovascular incident?

Was an accident or external violence involved?

What evidence of permanent neurological dysfunction exists?

Describe the severity of the neurological dysfunction and to what extent it limits the employee's activities (e.g. hemianopia or inability to communicate verbally or total and permanent neurological dysfunction in one or more limbs or significant intellectual or neuro-psychiatric impairment.)

4.4 Had **CANCER?**

The employee experiences the presence of a malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue including leukemia, malignant lymphomas and Hodgkin's disease **but excluding non-invasive cancers in situ, tumours in the presence of any human immunodeficiency virus and all skin cancers other than invasive malignant melanomas.** YES ☐ NO ☐

If YES, please state:

The date of first diagnosis: D D M M Y Y Y Y

The site and extent of the neoplasm:

Is it malignant or benign?

Has staging been carried out? YES ☐ NO ☐

If YES, please give details:

Please give details of all current treatment:

4.5 Had **RENAL FAILURE?**

Chronic irreversible failure of kidney function as a result of which regular dialysis is required. YES ☐ NO ☐

If YES, please report:

The date of diagnosis: D D M M Y Y Y Y

Did the condition present itself as chronic irreversible failure of both kidneys?

Has regular renal dialysis been instituted?

4.6 Had **PARALYSIS?**

The employee experiences total and permanent loss of the use of both legs and/or both arms through neurological deficit.

If YES, please report: YES ☐ NO ☐

The date of the paralysis: D D M M Y Y Y Y

What limbs are involved?

What was the cause?

Is paralysis due to neurological lesion?

Please indicate the extent of the paralysis:		Possible duration
Irreversible	☐	
Partial	☐	
Total	☐	
Temporary	☐	
Permanent	☐	

4.7 Had a **MAJOR ORGAN TRANSPLANT?**

The employee underwent a heart, lung, liver, pancreas, kidney or bone marrow transplant?

If YES, please state:

The date of the diagnosis: DDMMYYYY

The date of the organ transplant: DDMMYYYY

Which organ was transplanted?

The reason for the transplant:

4.8 Had **BLINDNESS?**

The employee experiences total and permanent loss of corrected or uncorrected Vision in both eyes.

YES NO

If YES, please state:

The date loss of vision occurred: DDMMYYYY

Cause of loss of vision:

Please indicate the extent of the loss of vision.		Possible Duration
Irreversible		
Partial		
Total		
Temporary		
Permanent		

If partial, indicate remaining sight:

Please give results of visual acuity testing:

Provide details of treatment recommended and results:

5. Please mention any other illnesses or injuries about which you have been consulted:

Nature of complaint	Date	Degree and severity
	DDMMYYYY	
	DDMMYYYY	
	DDMMYYYY	
	DDMMYYYY	

6. Are you aware of other doctors consulted by the claimant:

Nature of complaint	Date	Name of doctor
	DDMMYYYY	
	DDMMYYYY	
	DDMMYYYY	
	DDMMYYYY	

DOCTOR'S NAME:

POSTAL ADDRESS:

TEL NO.:

Postal code:

PRACTICE NO:

YEAR OF QUALIFICATION: D D M M Y Y Y Y

Signature of Member

D D M M Y Y Y Y

Date

CONSENT FORM

I, the above signed,

authorise Metropolitan Life Kenya Ltd (the Insurer) to provide medical information that I have supplied to any other person in the opinion of the Insurer, is involved in the assessment of the Claimant's disability. I further authorise the insurer to use this information should it be required for legal proceedings.