REFER DR LIEW FAH ONN

KINDLY CHECK COVERAGE

Tenaga Nasional Berhad (200866-W)
Bahagian TNB Global Business Solutions,
Tenaga Nasional Berhad,
Area 9 Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur.

Tel : 1300-80-5656
Fax : 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

Patient Information:

Patient Name	: NAGAMMAL A/P GOVINDAN	Issued Date	: 09/08/2025
Patient NRIC	: 540721085858	Issued Time	: 12:13:57
Employee Name	: NADARAJAN A/L VENOGOBAL	Employee No	: 10034375
Employee NRIC	: 510105075245	Relationship	: WIFE

GUARANTEE LETTER REFERENCE NUMBER: 9783033

Date of Visit : 09/08/2025
Attention : DATO SRI SURESH RAJ LACHMANAN (PHYSICIAN AND GASTROENTEROLOGIST)
ASSUNTA HOSPITAL
JLN TEMPLER

Tel No : 0376807000
Fax No : 0377844415

Medical Service Requested : HOSPITALIZATION

Medical Condition: Other Sepsis

Hospital Room and Board 110.00 perday
Room and Board Inclusive of Meals and Nursing Care only
Initial GL limit: RM 2,500.00

MEDICAL PROVIDERS TO CALL TNB HEALTHCARE IF LIMIT IS INSUFFICIENT FOR INTERIM AND FINAL BILLS WITH CLEAR BREAKDOWN AND REASONS INDICATED

Expenses entitlement is only for or directly related to medical/surgical condition referred to the Medical Condition as per above mentioned.

TNB reserves the right not to honor payment for unnecessary admissions, services, investigations or treatment rendered.

TNB will not pay or be responsible for any expenses in excess of the above entitlement or incurred for non-entitlement as indicated above. The excess amount must be recovered by the hospital from the patient upon their discharge.

Payment of claim is subject to timely submission of complete documents, i.e. within 14 working days from date of services or discharge.

Hospital to complete the Pre-Admission Form (PAF) in full, including estimated total cost, as it is a medico-legal document.

This GL **DOES NOT COVER** the following services:

i. Supplements – Please refer to TNB Medical Guidelines dated June 2021.
ii. Birth Control & Infertility investigation or treatment; Circumcision; Cosmetic Surgery; Injuries due to illegal activities; Dental Care (except in injury cases); Refractive Error Treatment; Platelet-Rich Plasma; Robotic surgeries; Speech Therapy; Research Product/ Procedure.
iii. Referrals to other Specialists are not covered by this Guarantee Letter.

Medication: One month supply ONLY

Remarks :
Any Additional Procedure/Treatment Must Seek Approval From TNBHC In Advance

TNBHC Will Exclude All Charges/Fee By Consultants/Specialist Who Failed To Request Cross Referral From TNBHC After Consultation & Procedure Done After 48 Hours.

All Treatment Coverage Must Adhere To TNB Guidelines And Policies.

This Guarantee Letter should be activated within 14 days from date of issue

Yours faithfully,

For and on behalf of
Tenaga Nasional Berhad

TNB HEALTHCARE CALL CENTRE

Authorised Signatory

SCANNED
09 AUG 2025
ASSUNTA HOSPITAL
ADMISSION DEPARTMENT

Assunta®
Heart & Art of Care

Name	: NAGAMMAL A/P M GOVINDAN
Visit No	: 00303562 / A25008926
DOB	: 21-07-1954
Sex	: FEMALE
Admission	: A25008926

INTERNAL REFERRAL

Primary Consultant : DATO SRI DR SURESH RAJ LACHMANAN

Referred to Doctor : OBSTETRICS & GYNAECOLOGY
DR. LIEW FAH ONN

Medical Summary : THICKENED UTERINE ENDOMETRIUM, PLEASE ADVISE

Date referred : 15-08-2025 Time : 12:05 PM

Purpose for referral : (•) Co - Management ( ) Complete takeover Management

How was referral communicated? : [ ] In person [x] By phone

Patient informed or referral : (•) Yes ( ) No

Cancel / Reject referral : [ ]

Signature of Referring Doctor,

15-08-2025 @ 12:05

To be filled by Doctor to Whom Referral Was Made

Attending Doctor Reply :

Signature of Attending Doctor,

TENAGA NASIONAL BERHAD

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59200 Kuala Lumpur

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Fax: 1300-22-5656
General Enquiry: tnbhealthcare@t
GL Request: gl@tnb.com.my

PRE-ADMISSION FORM / BORANG PRA-KEMASUKAN WAD

Private and Confidential/Sulit dan Persendirian

Part 1 (To be completed by patient)
Bahagian 1 (Untuk diisi oleh Pesakit)

1. Patient Name: *Nama Pesakit* Nagammal A/P m Govinden			2. NRIC (Old & New): *K.P. (Lama & Baru)* 540721 05 5155
3. a. Date of Birth: *Tarikh lahir* 21/7/1954.	b. Age: *Umur* 71	c. Sex: *Jantina*	☐Male *Laki-laki* ☑Female *Perempuan*
4. Employee/ Retiree Name: *Nama. Pekerja/Pesara:*	5. Employee No: *No. Pekerja:*		6. Admission / Planned Admission Date: *Tarikh kemasukan hospital*
7. Hospital Name: *Nama Hospital* Assunta Hospital			8. Name of Attending Doctor/ Speciality: *Nama Doktor yang merawat/ kepakaran:* Dr Hiru

Admission Reason / Sebab Kemasukan. *Please tick (√) and answer accordingly / Sila tanda (√) dan jawab soalan yang berkenaan*

9. ☐ Accident *Kemalangan*	a. Occurred on: *Berlaku pada* Date ____/____/____ *Tarikh* Time _____ *Masa* ☐ am *pagi* ☐ pm *petang* b. Details of Accident: *Butir-butir kemalangan*
10. ☐ Illness *Penyakit*	a. Symptoms first appeared on: *Tarikh simptom tersebut bermula* Date ____/____/____ *Tarikh* b. Doctor(s) consulted for this condition: *Doktor-doktor yang dilawati bagi penyakit ini* c. Doctor's or Clinic Contact(Address & Telephone): *Alamat & Telefon Doktor*

Declaration and authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief. I understand the delivery of this form is in no way an admission of TNB l and payment to the hospital by TNB or its representative shall not be construed as final admission of TNB's liability and for this and any further claims arising, TNB reserves al for evaluation as appropriate. I am fully aware of the limits as to my medical benefit coverage under the above-mentioned benefit plan. I hereby undertake to settle/reimbur medical expenses exceeding my entitlement under the said medical benefit plan, or that is not covered by the same. I agree that in the event I make, or have in the past mad false or untrue statement and/or suppressed and/or concealed any material facts in respect of my condition, the TNB shall absolutely forfeit my right to compensatic further reserves the right to recover any amounts paid earlier as a result thereof.

I hereby consent for TNB to process my personal data including my sensitive personal data in accordance with the Personal Data Protection Act 2010, its subsidiary legislatic applicable personal data protection code of practice. In furtherance to the consent, I hereby authorize any party including any medical practitioner, medical institution, he insurance company, company or individual, that has any record or knowledge of my medical information including and not limited to medical reports, medical records, backgro medical history, treatment, advice or, other personal information or details of my medical condition, mental condition, physical condition and/ or related accident/injury, to di such information to TNB or its representative for the purpose of administration and execution of my employment contract with TNB including to obtain the medical benefit fror as well as for other purpose(s) which is permissible under the laws. I also agree that TNB or its representative to use or disclose any of the information collected or held to third p in relation to any of the above purpose(s). This consent and authorization shall bind my successors and beneficiaries and remain valid notwithstanding my death and/or incapa so far as legally possible. I also agree that my consent and authorization on a copy of this form is valid and binding as the original copy.

Pengisytiharan dan pemberikuasa

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti TNB ke atas tuntutan saya dan saya bersetuju bahawa ba kepada hospital oleh TNB atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti TNB, dan TNB berhak menjalankan penilaian sewajarnya berh tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya. Saya memahami sepenuhnya had-had kemudahan perubatan saya di bawah pelan yang tersebut di atas, dengan ini berjanji akan menyelesaikan seborang a maun yang melebihi had kelayakan saya, yang tidak dilindungi oleh kemudahan perubatan berkenaan. Saya ber sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, TNB berhak membatalkan tuntutan saya dan menarik balik sebarang tun awal yang telah dibayar.

Saya dengan ini memberikan persetujuan kepada TNB untuk memproses data peribadi saya termasuk data peribadi sensitif saya selaras dengan Akta Perlindungan Peribadi 2010, perundangan subsidiarinya dan tataamalan perlindungan data peribadi yang terpakai. Lanjutan daripada persetujuan tersebut, saya dengan ini membe mana-mana pihak termasuk mana-mana pengamal perubatan, institusi perubatan, hospital, syarikat insurans, syarikat atau individu, yang mempunyai sebarang rekoa pengetahuan tentang maklumat perubatan saya termasuk dan tidak terhad kepada laporan perubatan, rekod perubatan, latar belakang atau sejarah perubatan, raw nasihat atau maklumat peribadi lain atau butiran keadaan perubatan, keadaan mental, keadaan fizikal saya dan/ atau kemalangan/kecederaan yang berkaitan, t mendedahkan maklumat tersebut kepada TNB atau wakilnya bagi tujuan pentadbiran dan pelaksanaan kontrak pekerjaan saya dengan TNB termasuk untuk mendapa faedah perubatan daripada TNB, serta untuk tujuan mana-mana hal yang sah di sisi undang-undang. Saya juga bersetuju untuk TNB atau wakilnya menggunakan mendedahkan sebarang maklumat yang dikumpul atau dipegang kepada pihak ketiga yang berkaitan bagi mana-mana tujuan di atas. Persetujuan dan kebenaran ini a mengikat waris-waris dan benefisiari saya, dan kekal sah meskipun saya telah meninggal dunia dan/atau tidak berupaya setakat yang dibenarkan di sisi undang-undang. juga bersetuju bahawa persetujuan dan kebenaran saya pada salinan borang ini adalah sah dan mengikat sebagaimana salinan asal.

Signature of Patient/ Guardian /*Tandatangan Pesakit/ Penjaga*	Signature of Employee/ Retiree / *Tandatangan Pekerja / Pesara*
X Nagammal Govinden	
Full Name/*Nama Penuh:*	Full Name/*Nama Penuh:*
IC No./*No. KP:*	IC No./*No. KP:*
Date/*Tarikh:*	Date/*Tarikh:*
Contact No / *No Telephone:*	Contact No / *No Telefon:*
	Relationship to Patient/ *Hubungan dengan Pesakit:*

NOTE: COMPLETION OF THIS PRE-ADMISSION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
NOTA: Melengkapkan borang Pra-Kemasukan Wad ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

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Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.c
GL Request: gl@tnb.com.my

Part 2 ADMISSION SECTION *(To be completed upon admission by Doctor)*

1.a. Patient name: Nagammal b. NRIC: 540710 5[illegible] c. Age: 71 d. Sex: ☐ Male ☐ Female

2. Admission No. / MRN: 00333562

3. Hospital Contact and Fax No:

4. Admission Date and Time: 9/8/25.

5. Expected days of stay / Discharge Date: STILL IN

6. a. Symptoms / Conditions requiring admission: REFERRED FOR RIGHT OVARIAN CYST, THICKENED ENDOMETRIUM b. How long is patient aware of the condition:

c. Patient's BP/ Temp/ Pulse: NORMAL

d. Date symptoms first appeared: 22/5/2023 - CYST e. Date first consulted: 15/8/2025

7. a. Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital Or any other facilities? ~~Yes~~ No.

b. Was this patient referred? If Yes, please provide details below: DATO'SRI DR SURESHRAJ LACHMANAN

c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed: UNKNOWN

Date	Disease / Disorder	Details of Treatment / Hospitalization	Doctor / Hospital/ Clinic

d. Can the condition be managed under the Outpatient basis? ~~Yes~~ ☐ No If no, please provide reasons of admission:

e. Is this medical condition an EMERGENCY condition ~~Yes~~ ☐ No

8. a. ~~Admitting Diagnosis~~: RIGHT OVARIAN CYST → ULTRASOUND 15/8/2025
THICK ENDOMETRIUM ☐ Provisional Diagnosis

c. Diagnosis confirmed on 15/8/2025 or Advised patient on 15/8/2025

d. Cause and pathology underlying the present diagnosis: UNKNOWN

e. Any possibility of relapse? ~~Yes~~ ~~No~~

9. Estimated Total Costs: RM_____ ASK STAFF

10a. Admission requires:
- ~~Hospitalisation~~
- ~~Day Care~~
- ~~On Patient's Request~~

11. Is the illness / condition related to: (please tick (✓) if YES) Please provide details:
- a) ☐ Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage or any complications rising therefrom
- b) ☐ Congenital / Hereditary diseases
- c) ☐ Influence of Drugs / Alcohol
- d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
- e) ☐ Cosmetic reason / Dental care / refractive errors correction
- f) ☐ AIDS / STD / VD/ HIV
- g) ☐ Self-inflicted injuries / Violation of laws / Strike / Riots
- h) ☐ None of the above

12. Medical treatment, investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):
NEED CT SCAN OF PELVIS

13. Any other medical/surgical conditions present? ☐ No ☐ Yes, details below:
a. HYPERTENSION since __/__/2004
b. DIABETES MELLITUS since __/__/__

14. Was the patient pregnant at the time of Hospitalization? (For Female Only)
~~No~~ ~~Yes,~~ _____ months

15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:
NO

b. Please indicate date/time of accident: (dd/mm/yy) __/__/__ (hrs) _____ ☐ am ☐ pm

16. *I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as stated above represent n opinion of his/her condition.*

15/8/2024
Date

Name & Signature of Attending Doctor
DR's Contact no and Email addresss:

DR. LIEW FAH ONN
MBBS (Mal), MRCOG (UK)
LLB (Hons)(London), CLP (Mal)
MMC-Full Registration No. 2371[illegible]
Consultant Obstetrician & Gynaecolc
Assunta Hospital
Doctor / Hospital Stamp CODE 2008)