CUEPACS ETIQA MUTIARA PLUS

Level 3 Bangunan PSM no 17B Jalan Bangsar 59200 Kuala Lumpur
Tel : 0322836364/6361 Faks : 0322836272 H/p : 017-6340518

Pastikan document **disahkan benar lengkap mengikut arahan** sebelum dihantar **agar tidak berlaku penolakan.**

PERKARA: BORANG SEPARA KEKAL (PPD)

NOTA : Nama Penuh Peserta merujuk kepada **PESAKIT**

- Sijil penyertaan **TKM 0679**. Jika tiada tetapi menjadi ahli **melebihi 60 hari** peserta layak membuat tuntutan. Sila lampirkan surat pengakuan jika tiada sijil.

Dokumen yang perlu dilampirkan:

TYPES OF CLAIMS	DOCUMENTS REQUIRED
Tuntutan Hilang Anggota Separa Kekal	**1) Borang tuntutan hilang anggota separa kekal** **2) Hilang anggota separa kekal – laporan perubatan yang dilengkapi oleh doctor** **3) Salinan kad pengenalan** **4) Gambar yang diambil dari dekat sebagai bukti kehilangan / gamabr penuh peserta** **5) Salinan x-ray, MRI, CT Scan atau laporan radiologi lain yang disahkan benar** **6) Dokumen sokongan yang lain (jika ada)**

Jika dokumen sokongan diberikan dalam salinan, dokumen tersebut mestilah disahkan oleh mereka yang dibenarkan oleh Syarikat, Pesuruhjaya Sumpah, 'Notary Public', Peguam, Jaksa Pendamai, Ahli Parlimen, Ketua Balai Polis, Penghulu atau Pegawai Daerah.

****PERMOHONAN HENDAKLAH DIPOSKAN MENGIKUT ALAMAT KAMI DI BANGSAR DAN PERMOHONAN INI TIDAK BOLEH DIFAKSKAN KEPADA KAMI****

Types Of Claims	Documents Required
Personal Accident Rider / Dismemberment / PPD	1. Permanent Partial Dismemberment Claim Form 2. Permanent Partial Dismemberment Statement of Medical Examiner 3. Certified copy of Insured / Life Assured / Person Covered Participant's IC 4. Certified copy of police report, (if any) 5. Close-up photograph as proof of loss/Full photo of claimant 6. Consent letter for medical report extraction 7. Certified copy of X-ray, MRI, Ct Scan or other radiology reports 8. Other supporting documents (if applicable)

Note: The items listed served as the guidelines for claims submission. The Company reserves the right to request for further information or documents deemed necessary.

PERMANENT PARTIAL DISMEMBERMENT CLAIM FORM (GROUP CLAIM)

SECTION A

Every question must be fully answered and the Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Contract No: ……..

Broker/ Account Manager's Name : .....

Broker/ Account Manager's Contact No. : .....

Instruction – Supporting documents required

- ☐ Permanent Partial Dismemberment Claim Form
- ☐ Permanent Partial Dismemberment - Statement of Medical Examiner
- ☐ Certified copy of Participant and/or Claimant's IC
- ☐ Certified copy of police report, (if any)
- ☐ Close-up photograph as proof of loss / Full photo of claimant
- ☐ Certified copy of X-ray, MRI, CT Scan or other radiology reports
- ☐ Other supporting documents (if applicable)

1. Participant's Details

Name of Participant : ……

NRIC No. : …….. BC / Old IC No. : …… Age : ……..

Sex : ☐ Male ☐ Female Date of Birth : …….…… Marital Status : ……

Correspondence Address : ……

……

Mobile Phone No. : ……..…..…..... Office Phone No. : ..... House Phone No. : ……..…..…..

E-mail Address : ……

If working, please state :

i) Present Occupation : ……

ii) Exact nature of occupation and duties : ……

iii) Involved in manual work ? ☐ Yes ☐ No

iv) Name & address of employer : ……

v) Office Telephone No. : ..... vi) Date join company : .....

2. Claimant's Details (If other than Participant)

Name of Claimant : ……

NRIC No.: ……..... Old IC No. : ……

Correspondence Address: ……

……

Mobile Phone No. : ……..…..…..... Office Phone No. : ..... House Phone No. : ……..…..…..

Fax No. : …… E-mail Address: ……

3. Condition / Disability due to Accident

i. Date of accident happen : .....(dd/mm/yyyy) Time of accident :.....(am/pm)

ii. Place of accident :.....

iii. How did the accident happen?.....

iv. Details of injuries sustained :.....

v. Date absent from work :.....(dd/mm/yyyy) Date return to work :.....(dd/mm/yyyy)

vi. Date of first consultation : .....(dd/mm/yyyy)

vii. Name of **first** clinic / hospital consulted for this illness / injury : ……

viii. Address of the clinic / hospital : ……

ix. Contact no. of the clinic / hospital : ……..

4. Condition / Disability due to Illness

i. Describe fully the symptoms for which you consulted a medical practitioner.

……..

ii. Date symptoms **first** commenced ……(dd/mm/yyyy)

iii. Date you **first** consulted doctor for this condition.……(dd/mm/yyyy)

iv. Name & address of doctor you **first** consulted for this condition……

……

v. What was the diagnosis? ……

vi. What treatment are you currently receiving? ……

5. Did you suffer amputation of limbs? ☐ Yes ☐ No

i. If yes, please stated which limb(s) is/are affected and exact location of amputation

……

6. Did you suffer loss of use of limbs and /or fingers, loss of eyes etc? ☐ Yes ☐ No

i. If yes, please give exact details……

7. Please give details of doctors that have been consulted in connection with this injury / illness:

Date of Consultation	Name of Doctor (s)	Name of clinic / Hospital & Address	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)

8. Name(s) of all medical practitioner(s) and clinic(s) / hospital(s) which (I/Participant*) have /has, sought or received medical treatment, advice, consultation and/or check-up within the **past three (3) years**.

Date of Consultation or Treatment etc.	Name of Doctor (s)	Name, Address and Telephone No of Clinic / Hospital

9. State the name and address of your regular doctor ……

10. Are there other policies in force on the Participant's life taken with other companies? ☐ Yes ☐ No
If yes, please furnish the following details :

Name of Company	Policy No.	Type of Coverage	Amount of Compensation (RM)	Date which the policies were effected
…….	…….	…….	…….	……..
…….	…….	…….	…….	……..

11. Please state bank account details in order for us to credit the payment directly into Claimant's bank account.

Bank : ……Bank Branch: ……Account No: ……..……..

Bank Account Holder Name: ……...

Company Registration No.……(Eg:266243D)

If the above bank account is a joint account, please provide below details:

Second account holder name : ……

Second account holder NRIC :……

The Payment which has been made based on the account details provided by you will be deemed as full payment and we shall be discharged from any existing and future claim and demand in relation to it

DECLARATION

I hereby declare that the foregoing answers and statements on the Participant are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish to Etiqa Family Takaful Berhad or its representative any information that maybe required concerning my health conditions, for settlement of this claim. I agree that Etiqa Family Takaful Berhad or its representative may use or disclose any of the information collected or held to third parties such as reinsurers, medical examiner or medical consultant, claims investigator and etc. within or outside Malaysia for the purpose of processing the claim. I agree that a photocopy of this authorization shall be considered as effective and valid as original.

_____ _____
Signature / Thumb print of Participant

Name:_____

Date: _____

_____
Signature / Thumb print of Claimant (if different from Participant)

Name:_____

Date: _____

_____
Signature of Witness

Name:_____

NRIC No : _____

Date : _____

_____
Authorized Signature of Contract Holder & Company's Stamp

Full Name :_____

Designation: _____

Date :_____

Contact No._____

LETTER OF AUTHORISATION / CONSENT
TO OBTAIN FURTHER INFORMATION (LIVING TAKAFUL CLAIM)

To Whom It May Concern,

Contract No. : _____

Dear Sir / Madam,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organization, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of the employment, financial, health or medical history of myself ("the Participant") and to provide such information to Etiqa Family Takaful Berhad or its authorised agents and / or employees.

I expressly waived all provisions of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on myself in a professional and / or client capacity and I further release the Information Provider(s) and its agent / staff from any liability whatsoever that may rise, in supplying such information requested by the Company.

This authorisation / consent is irrevocable and a copy of it will have the same effect and validity as the original.

_____
Signature / Thumb print of Participant

Name : _____

NRIC : _____

Old IC : _____

Birth Cert No. (if minor) : _____

Tel No. : _____

Date : _____

_____
Signature of Contract holder (If Participant is a minor)

Name : _____

NRIC : _____

Old IC : _____

Tel No. : _____

Date : _____

Etiqa Family Takaful Berhad (266243D)
(Formerly known as Etiqa Takaful Berhad)
(Licensed under Islamic Financial Services Act 2013 and regulated by Bank Negara Malaysia)
Level 17, Tower B, Dataran Maybank, No 1, Jalan Maarof, 59000 Kuala Lumpur
Etiqa Oneline 1300 13 8888 E info@etiqa.com.my
Etiqa Healthcare 1800 88 9888 F 1800 22 9988 E etiqahealthcare@etiqa.com.my www.etiqa.com.my
Ahli Kumpulan Maybank

PERMANENT PARTIAL DISMEMBERMENT - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries / illness sustained.

2. Expenses incurred to obtain this report will be borne by the Participant.

Contract No: ……..

1. Name of Patient: ……..
2. NRIC No. : ……..... BC / Old IC No. : ……..Age: ……..
3. Occupation as indicated to you :……
4. Date of first consultation with you: ……..... (dd/mm/yyyy) Time : ……..……(am/pm)
5. Diagnosis: ……..
6. Date of diagnosis: ……..(dd/mm/yyyy)
7. What was the underlying cause and pathology of the above diagnosis?

   ……
8. If the cause was due to accident, please state
   i. Date of Accident : …….. (dd/mm/yyyy) Time : ……..…(am/pm)
   ii. Describe in detail the nature of accident as related to you by the patient:

   .....……..
   iii. Was the patient under the influence of intoxicating liquor, drug or narcotic at the time of accident? ☐ Yes ☐ No
9. Treatment given including follow up consultation :-

Date of consultation (dd/mm/yyyy)	Treatment given	Healing Progress

10. Details of Hospitalization

Name of Hospital	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)	Type of Surgery Performed	Date of Surgery (dd/mm/yyyy)	Other Diagnosis Procedures or Treatment

11. Was the patient referred to you by any doctor? ☐ Yes ☐ No
    i. If yes, please indicate the name of doctor and address of the clinic / hospital.

    ……..
    ii. Please attach a copy of the referral letter, if any.

12. Date of full weight bearing ……(dd/mm/yyyy)

13. Was the healing complicated, eg: infection, malunion etc? ☐ Yes ☐ No

i. If yes, please give details of complications……

14. Did the patient suffer amputation of limbs? ☐Yes ☐ No

i. If yes, please stated level of amputation seen (proximal, middle, distal)

……

15. Last date of consultation : ……..(dd/mm/yyyy)

16. Condition of healing / recovery of the injury / illness as at last consultation date

……

17. Did the patient suffer any loss of use of limbs and /or fingers? ☐ Yes ☐ No

Please state the power of patient's upper and lower limbs as at last consultation date

i. Right Upper Limb : …….. Right Lower Limb :……..

ii. Left Upper Limb : …….. Left Lower Limb : ……..

18. Did the patient suffer any loss of eyes? ☐ Yes ☐ No

Please give details on patient's Visual Acuity as at last consultation; (i) Right eye : …….. (ii) Left eye : ……..

19. Did the patient suffer any loss of hearing? ☐ Yes ☐ No

Please give details on patient's hearing as at last consultation, (i) Right ear : ……..db (ii) Left ear : ……db

20. Does the patient suffer any limitation of movement on any joint as at last consultation date? ☐ Yes ☐ No

i. If yes, please state the limitation and range of movement

……

21. Please state the percentage(%) of whole person impairment according to AMA guidelines (completed by Specialist)

……

22. If the patient was diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him / her starting from the first recording done :

Date (dd/mm/yyyy)	Readings of Blood Pressure	Date (dd/mm/yyyy)	Results for Blood Glucose (Fasting)
i. ……	……	i. ……	……
ii. ……	……	ii. ……	……

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : _____

Name of Doctor : _____ Qualification : _____

Telephone No. : _____ Fax No. : _____

Date : _____(dd/mm/yyyy)

Official Stamp of Doctor : Name and Address of Clinic / Hospital Official Stamp

_____ _____