CUEPACS ETIQA MUTIARA PLUS

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BORANG TUNTUTAN HOSPITAL

UP : _____

SILA PASTIKAN @ DAPATKAN

SECTION A

1. BAGI TUNTUNTAN **HB** SEBANYAK RM 500.00 ATAU KURANG DAN TEMPOH POLISI LEBIH DARIPADA 2 TAHUN DARI PERMULAAN POLISI SILA KEMUKAKAN **DISCHARGE SUMMARY @ DISCHARGE NOTE** DENGAN PENGESAHAN DOKTOR DAN JUGA T/TGN & COP HOSPITAL.

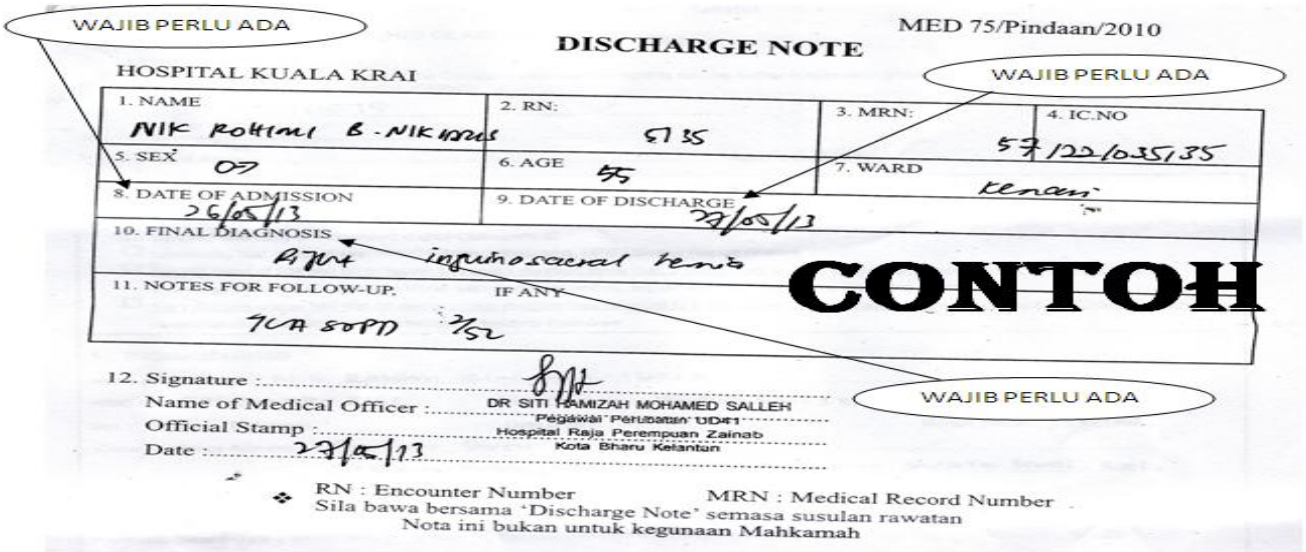
SECTION B

2. BAGI TUNTUTAN **HB** YANG MELEBIHI **RM 500.00** @ TEMPOH POLISI KURANG ATAU SAMA DENGAN **2 TAHUN** DARI PERMULAAN SILA KEMUKAKAN BORANG YANG DILAMPIRKAN **"STATEMENT OF MEDICAL EXAMINER"** DENGAN PENGESAHAN DOKTOR DAN JUGA T/TGN & COP HOSPITAL.

NOTE 1: Sila lampikan juga

-SALINAN IC PESERTA & PENUNTUT
-SALINAN BIL BAYARAN / INVOIS HOSPITAL YANG DI SAHKAN (HOSPITAL SWASTA SAHAJA)
-SALINAN BUKU BANK @ STATEMENT BANK YANG TERTERA NO. AKAUN, NAMA DAN NO IC DIPERLUKAN UNTUK BAYARAN TERUS KE AKAUN AHLI.

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



Types Of Claims	Documents Required
Hospital Benefit	1. Hospital and Surgical Claim Form / Discharge Medical Form 2. Medical report completed by attending doctor (for claim amount more than RM500) 3. Discharge note or summary with diagnosis(for claim amount less than RM500) 4. Certified copy of in-patient medical bill 5. Other supporting documents (if applicable)
Hospital & Surgical	1. Hospitalization Claim Form 2. Medical report or Attending Physician Statement 3. Original Hospital Bill 4. Original Official Receipt(s) 5. Original or certified copy of Discharge summary with medical history, diagnosis and treatment rendered 6. Referral Letter(s) from the referring clinic

HOSPITALISATION BENEFIT (HB) 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

- ☐ HB Claim Form
- ☐ Certified true copy of hospital bill / invoice
- ☐ Certified true copy of Participant and/or Claimant's IC
- ☐ Labarotary test result, X-ray, MRI/CT Scan, Ultrasound, HPE / Biopsy Report (if any)
- ☐ For HB claim of RM 500.00 or lesser and policy duration more than 2 years from policy inception or reinstatement, whichever is later
  Discharge Summary / Discharge Notes with diagnosis written, signed and stamped by the attending doctor
- ☐ For HB claim above RM 500.00 and/or policy duration less or equal to 2 years from policy inception or reinstatement, whichever is later
  Hospitalisation Benefit (HB) - Statement of Medical Examiner

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. : ……..…..…..... House Phone No. : ……..…..….

E-mail Address : …….

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

Name of Claimant : ……

NRIC No.: ……..... Old IC No. : ……

Correspondence Address: ……

……

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

E-mail Address: ……

3. Hospitalisation's Details

i. Name of illness / diagnosis : .....

ii. Date of diagnosis : .....(dd/mm/yyyy)

iii. Symptoms of illness : .....

iv. How long the symptoms existed prior to **first** hospitalisation ? .....

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

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

vii. Address of the clinic / hospital : ……

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

ix. Date of Admission: .....(dd/mm/yyyy)

x. Date of Discharge: .....(dd/mm/yyyy)

4. 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

Name, address and contact no. of the Participant's regular doctor other than above :

……..……..

5. 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
…….	…….	…….	……	……..

6. 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 Life Assured	Signature of Witness	Authorized Signature of Contract Holder & Company's Stamp
Name:_____	Name :_____	Full Name : _____
Date : _____	NRIC No : _____	Designation: -_____
	Date : _____	Date :_____
		Contact No._____

LETTER OF AUTHORISATION / CONSENT

To Obtain Further Medical information

TO WHOM IT MAY CONCERN

Name of Participant …..…….

NRIC No. ……(New) ……..(Old)

Contract No. ……...

I, ……..., NRIC No. …… hereby authorize and give my consent to any medical practitioner, physician, surgeon, nurse, medical staff, clinic, hospital, medical centre, insurance company or organization or individual concerned ("the information provider") that may have any record or knowledge of health or medical history of the above stated ("Participant") and to provide such information to Etiqa Family Takaful Berhad and its authorized service provider and/or its employees in order to process my takaful claim.

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 arise, in supplying such information requested by the Company.

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

……
Signature of Participant / Claimant (If Participant is a minor)

Name: ……..

Relationship with Participant: ……...

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

HOSPITALISATION BENEFIT (HB) - 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.
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. Date of Admission: ……..(dd/mm/yyyy) Time : ……...(am/pm)
4. Date of Discharge: ……..(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. Did you inform the patient of the diagnosis, if so, when? ……... (dd/mm/yyyy)
9. When you first saw the patient for this illness/ condition …… (dd/mm/yyyy)
10. Have any investigations, tests or procedures been performed? ☐ Yes ☐ No
    i. If so, what were the results?……
    ii. Please furnish a certified true copy of the results
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. Who was the doctor who first diagnosed the patient for this illness? Please provide name and address of the doctor

    ……
13. According to the patient:
    i. What were the symptoms complained? ……
    ii. How long had he/she been experiencing these symptoms? ……..
    iii. Did the patient already know or aware he/she has this diagnosis before the first consultation with you? ☐ Yes ☐ No
        a. Since when? …… (dd/mm/yyyy)
    iv. Has the patient previously received any treatment for the above symptom/diagnosis? ☐ Yes ☐ No
        a. If yes, please furnish name and address of the doctor

           ……
        b. Date of last treatment the patient received before first consultation with you: ……(dd/mm/yyyy)
        c. Type of treatments the patient received upon first diagnosed of this illness: .....

           ……
14. Was the condition ☐ Congenital ☐ Hereditary ☐ Alcohol ☐ Nervous
    ☐ AIDS/HIV ☐ Drug Abuse ☐ Cosmetic ☐ Mental ☐ Sexually Transmitted Disease

15. Any surgery/procedure performed? Yes No

i. If yes, please state type of surgery/procedure performed

Type of surgery/procedure	Date (dd/mm/yyyy)	Name of Doctor & Hospital

16. Nature of medical treatment given ……..

17. Any possibility of relapse? ☐ Yes ☐ No

18. Has the patient previously been treated or hospitalized in this hospital or other hospital for any other disease? Yes ☐ No ☐

i. If yes, please state

Date (dd/mm/yyyy)	Diagnosis	Name of Doctor & Hospital

19. 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. ……	……..
iii. ……	……..	iii. ……..	……..

20. For female only - was the patient pregnant at the time of hospitalisation? ☐ Yes ☐ No

i. If so, for how many weeks? ……

ii. Was illness caused directly or indirectly by pregnancy / child birth / caesarian / abortion / miscarriage / infertility and all complications arising therefrom? ☐ Yes ☐ No

If yes, please elaborate : ……

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 Consultant Neurologist

……..

Name of Consultant Neurologist

Professional Qualification: ……..……..

……

.

Clinic / Hospital Stamp:

Date: ……..……

Tel. No:……..