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 TUNTUAN KEMATIAN

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

- Sijil penyertaan **TKM 0679/TTMW000004**. Jika tiada tetapi menjadi ahli **melebihi 60 hari** peserta layak membuat tuntutan. Sila lampirkan surat pengakuan jika tiada sijil.

Dokumen yang perlu dilampirkan:

Sila sertakan dokumen-dokumen berikut bersama dengan tuntutan ini (Salinan Disahkan) :

TYPES OF CLAIMS	DOCUMENTS REQUIRED
Death Claim	1) Salinan sijil / Policy contract. 2) Borang Tuntutan Kematian 3) Borang Doktor Statement (for policy duration < 5 years) 4) Sijil Kematian yang disahkan 5) Sijil Kematian / Permit penguburan yang disahkan 6) Sijil perkahwinan yang disahkan 7) Salinan i/c peserta dan penuntut yang disahkan 8) Surat kebenaran yang disertakan 9) Salinan sijil faraid jika ada 10) Lain-lain dokumen yang berkaitan <u>Kematian akibat kemalangan</u> 11) Salinan laporan polis yang disahkan 12) Detailed Post Mortem report jika ada 13) Salinan Toxicology report jika ada 14) Salinan keratin akbar 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****

ETIQA GROUP CLAIMS SUBMISSION CHECKLIST

GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

Note: We reserve the rights to request further documents if required

Please tick (✓) where applicable;

COMPULSORY FOR ALL CLAIM TYPE SUBMISSION:	
	Etiqa Group Claim Form : Group Major & Hospital Benefits Claims
	Certified copy of Claimant's / Payee's NRIC
	Bank Account Details of Payee and Company Registration Number (If payee is Contract/Policy holder)

DEATH / FUNERAL EXPANSES / KHAIRAT CLAIM	
	Death Statement of Medical Examiner (for policy duration < 5 years)
	Certified copy of Death Certificate
	Proof of relationship between claimant and Participant/Life Assured: Certified copy of ANY one below: - Marriage/ Nikah Certificate if claimant is spouse - Birth Certificate (s) of Child if claimant is child/Children - Birth Certificate (s) of Deceased if claimant is parent (s) - If above is not available, please submit statutory declaration
	Certified copy Sijil Faraid /Court Orders / Letter of Administration (if applicable)
	If death occurred in Overseas: - Confirmation letter from National Registration Department (for death outside of Malaysia) - Death Certificate issued by the country where death occurred (if any) - Certification of death from the hospital where death occurred (if any) - Certification of death from the Malaysian Embassy in the foreign country where death occurred (if an

ACCIDENTAL DEATH CLAIM	
	Death Statement of Medical Examiner
	Certified copy of Death Certificate
	Certified copy of : Police Report , Post Mortem report (if any), Newspaper/Online News cutting (Where applicable)
	Proof of relationship between claimant and Participant/Life Assured : Certified copy of ANY one below: - Marriage/ Nikah Certificate if claimant is spouse - Birth Certificate (s) of Child if claimant is child/Children - Birth Certificate (s) of Deceased if claimant is parent (s) - If above is not available, please submit statutory declaration
	Certified copy : Sijil Faraid /Court Orders / Letter of Administration (Where applicable)

TOTAL & PERMANENT DISABILITY CLAIM	
	Total & Permanent Disability Claim - Statement Of Medical Examiner (Group) Section B (Completion of Section B must be done six months after the diagnosis/disability date)
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports
	Certified copy of Medically Boarded Out letter from employer (if employed)
	Certified copy Other supporting documents (if applicable) etc. SOSCO Pencen Illat medical reports/letters

PERMANENT PARTIAL DISMEMBERMENT/ DISABILITY CLAIM	
	Permanent Partial Dismemberment - Statement Of Medical Examiner Section B
	(Completion of Section B must be done six months after the diagnosis/disability date)
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

ACCIDENT MEDICAL REIMBURSEMENT (AMR) CLAIM	
	Original official receipts and bills
	Discharge note /summary with diagnosis or Medical Report
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports
	Certified copy other supporting documents (if applicable) etc. Police report

HOSPITAL BENEFIT / DAILY HOSPITAL ALLOWANCE CLAIM	
	Original official receipts and bills
	Discharge note /summary with diagnosis or Medical Report
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

TERMINAL ILLNESS BENEFIT CLAIM	
	Critical Illness (Others) – Statement Of Medical Examiner (Group Claim)
	Letter from attending physician stating the current patient's condition, treatment and prognosis.
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

CRITICAL ILLNESS BENEFIT CLAIM

Medical Examiner Form to be completed according to the type of critical illness:

1. Critical Illness (Cancer) – Statement Of Medical Examiner (Group Claim)
2. Critical Illness (Stroke) – Statement Of Medical Examiner (Group Claim)
3. Critical Illness (Renal Failure) – Statement Of Medical Examiner (Group Claim)
4. Critical Illness (Heart) – Statement Of Medical Examiner (Group Claim)
5. Critical Illness (Others) – Statement Of Medical Examiner (Group Claim)

List Of Covered Events And The Required Medical Evidence

Stroke - CT Scan / MRI Report of Brain	**Parkinson's Disease** - All relevant investigation results in support of the diagnosis
Heart Attack / Cardiomyopathy - Cardiac Enzymes Assay results (CK-MB,Troponin T / Troponin I) - ECG tracing - Echocardiogram / Coronary Angiogram report	**Blindness - Permanent and Irreversible** - Visual Acuity Report on both eyes to be done by an ophthalmologist * CMC to be completed by an Ophthalmologist.
Angioplasty and other invasive treatments for coronary artery disease - Coronary Angiogram Report **Coronary Artery By-Pass Surgery** - Coronary Artery By-Pass Surgery Report **Heart Valve Replacement / Surgery** - Heart Valve Surgery Report	**Chronic Lung Disease** - Pulmonary Function Test results - Arterial Blood Gas test results - FEV 1 Test results - Relevant investigation results
Cancer - Histopathology Report (HPE report) - CT Scan / MRI Reports, if available - Bone Marrow Aspiration / Trephine Biopsy Report (Leukemia only) - Blood and laboratory test report	**Motor Neuron Disease** - CT Scan/ MRI report of the Brain and Spine - Electromyography (EMG) test results - All relevant investigation results in support of the diagnosis - Medical Report to be completed by Neurologist
Renal / Kidney Failure / Medullary Cystic Disease - Kidney Dialysis Report / Dialysis Receipts - Kidney/Renal Biopsy Report (if any) - Blood test results	**Multiple Sclerosis** - CT Scan & MRI Report of Brain & Spine - Nerve conduction study / Evoked potential test * Medical Report to be completed by Neurologist
Systemic Lupus Erythematous (SLE) With Lupus Nephritis - Lupus Erythematous (LE) cell blood test results - Anti-DNA Antibodies & Renal biopsy report - Urine FEME results over past 6 months - Renal function tests with eGFR results over past 6 months	**Coma – resulting in permanent neurological deficit with persisting clinical symptoms** - ICU report and supporting documents for being in come > 96 hours - X-ray/CT Scan/ MRI Reports - Medical Report to be completed by Neurologist
Fulminant Viral Hepatitis / End-Stage Liver Failure/ Chronic Liver Disease - CT Scan Report of Liver - Liver Function Test results - Abdominal ultrasound - Hepatitis viral serology test - Any other laboratory or pathology reports	**Muscular Dystrophy** - Lumbar puncture report - Electromyography (EMG) test results - Muscles biopsy - All relevant investigation results in support of the diagnosis - Medical Report to be completed by Neurologist
Brain Surgery - Brain Surgery Report	**Terminal Disease** - All relevant investigation results in support of the diagnosis - Medical Report stating patient not receiving active treatment other than pain relief.
Benign Brain Tumor - CT Scan / MRI Report of Brain - Histopathology Report, if available	**Chronic Aplastic Anemia - resulting in permanent Bone Marrow Failure** - All relevant blood and bone marrow investigation results in support of the diagnosis - Bone Marrow transplantation report
Major Head Trauma - CT Scan / MRI Report of Brain - Surgery report - Police report, if any	**Alzheimer's disease/Severe Dementia / Parkinson's disease** - All relevant investigation in support of the diagnosis - Medical Report to be completed by Neurologist - Physio / Rehabilitation Reports (if Any)
Bacterial Meningitis / Encephalitis - CT Scan / MRI Report of Brain /Spine - CMC to be completed by Consultant Neurologist - Lumbar puncture test report	**Deafness – Permanent and Irreversible** - Audiogram Report (Latest Report) - Pure Tone Audiometry reports (Latest Report)
Major Burns / Third Degree Burns - Total Body Surface Area Burn Assessment Report	**Loss of Speech** - Laryngoscopy report
Paralysis / Paraplegia / Paralysis of limbs - X-ray/CT Scan/ MRI Reports, if available - Medical Report to be completed by Neurologist	**Major Organ / Bone Marrow Transplant** -Transplantation report of heart or lung /liver /kidney /pancreas / bone marrow

Note: Kindly contact our sales/agents or customer service for illness/requirements which is not listed above.

GROUP CLAIMS CLAIMANT STATEMENT FORM

GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

Type of Claims

Note: Please tick (✓) the relevant claims type & refer to Claims Checklist for list of required supporting documents for submission

☐ Hospitalisation Benefit (HB) ☐ Total Permanent Disability ☐ Terminal Illness ☐ Accidental Death

☐ Critical Illness ☐ Partial Permanent Disability ☐ AIR Weekly Indemnity ☐ Death ☐ Khairat

Section A: Details of Person Covered/ Deceased

Contract No				
Name of Contract Holder				
Name of person Covered				
MyKad No. OR Other ID No.				
Contact Details	**Phone**	**Mobile:**	**House:**	**Office:**
	Fax No.		**Email**	
Current Corresponding Address	**Postcode:**	**Town:**	**State:**	
Current Occupation & Job Nature				

Section B: Details of Claimant

Relationship with Person Covered	☐ **Own**	☐ **Spouse**	☐ **Child**	☐ **Parent**
	☐ **Employer**	☐ **Contract Holder**	☐ **Others** *(Please specify:*	*)*
Name				
MyKad No. OR Other ID No.		**Benefit Sum Assured** *(Applicable for Employers only)*	**RM**	
Contact Details	**Phone**	**Mobile:**	**House:**	**Office:**
	Fax No.		**Email**	
Current Corresponding Address	**Postcode:**	**Town:**	**State:**	

Bank Account Details *(Current or Savings Account)*	**Bank Name**	
	Bank Account Holder Name	
	Account Type	☐ **Current** ☐ **Savings**
	Ac count Number	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section C: Details of Claims

Claim Type : Death/ Accidental Death /Funeral Expanses/ Khairat Claim

Date of Death *(dd/mm/yyyy)*		**Last Working Date (If employed)**	
Any Post Mortem Done?	☐ **Yes** *(Please provide copy of the report)* ☐ **No**		

Claim Type : Hospitalisation /Critical Illness/ Terminal illness /AIR Weekly Indemnity Claim

Date of Admission *(dd/mm/yyyy)*		**Date of Discharge** *(dd/mm/yyyy)*	
Admitted Hospital			
Diagnosis			
First Date of Signs & Symptom for the Diagnosis *(dd/mm/yyyy)*		**Medical Certificate (MC) Dates** *(dd/mm/yyyy)*	
Date of Accident *(dd/mm/yyyy)*		**Place of accident**	

Claim Type : Total / Partial Permanent Disability Claim

Date of Admission *(dd/mm/yyyy)*		**Date of Discharge** *(dd/mm/yyyy)*	
Diagnosis			
First Date of Signs & Symptom for the Diagnosis *(dd/mm/yyyy)*		**Medical Certificate (MC) Dates** *(dd/mm/yyyy)*	
Date of MC/ Prolonged Illness Leave	**Start Date** *(dd/mm/yyyy):*	**End Date** *(dd/mm/yyyy):*	
Current Salary Status	☐ **Full Salary**	☐ **Half Salary**	☐ **No Salary**
Last Drawn Monthly Basic Salary	**Paid Date** *(dd/mm/yyyy*	**Salary Amount** **RM**	
Last Working Date *(dd/mm/yyyy)*		**Date of Resignation /Medically Boarded out / Early Retirement (if any)**	

DECLARATION

I do solemnly and sincerely declare that I am the nominee/administrator/beneficiary for the Takaful benefit of the deceased and further declare as follows:-

1. That the foregoing answers and statements on the Deceased are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
2. That any difference, if any, in respect of the details contained in the enclosed supporting document and the information presented to Etiqa Takaful Berhad(Etiqa) in this form refers to the same person. I understand and agree that Etiqa has the sole discretion to reject this application if the information given is false or insufficient.
3. That the original certificate whether or not enclosed therein (if any), due to loss or mutilated, belongs to the deceased.
4. And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish Etiqa Takaful Berhad or its representative any information that may be required concerning my health conditions, for settlement of this claim. I agree that Etiqa 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.
5. I, agree, consent and allow Etiqa Family Takaful Berhad (hereinafter called "Etiqa Takaful") to process my personal data (including sensitive personal data) ('Personal Data') with the intention of processing this Claim Form, in compliance with the provisions of the Personal Data Protection Act 2010.
6. I, understand and agree that any Personal Data collected or held by Etiqa Takaful contained in this Claim Form may be held, used, processed and disclosed by Etiqa Takaful to individuals and/or organizations related to and associated with Etiqa Takaful or any selected third party (within or outside Malaysia, including medical institutions, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this Claim Form and providing subsequent service related to it and to communicate with me for such purposes.
7. I agree that a copy of documents submitted shall be as valid as the original. I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.

Date **Date:**

DEATH - 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 Deceased for illnesses / injuries sustained.**
2. **Expenses incurred to obtain this report will be borne by the Claimant.**

POLICY / CONTRACT NO: _____

1. Name of the Deceased in full	
2. NRIC / Old IC/ Other Identity No(Please Specify)	
3. Age	
4. Deceased's Address at time of death	
5. Occupation at the time of death	
6. Date of death	(dd/mm/yyyy)
7. Place of death	
8. Cause of death	
9. Disease or condition directly leading to death	
10. By whom was the disease or condition first diagnosed Please provide name and address of doctor	
11. Was the Deceased/family informed of the diagnosis	☐ Yes ☐ No
12. When did the Deceased first consult you?	(dd/mm/yyyy)
13. Diagnosis at the first consultation	
14. In your opinion, how long Deceased experienced the sign or symptoms?	
15. Are you the Deceased's regular / family doctor ?	☐ Yes ☐ No
16. If no, please give name and address of Deceased's regular doctor (if known)	
17. Was the Deceased referred to you by another doctor? If yes, please give name and address of the doctor	☐ Yes ☐ No
18. Did you attend to Deceased's last illness If no, please give name and address of the attending doctor	☐ Yes ☐ No
19. Was death due to self-infliction	☐ Yes ☐ No
IF DEATH DUE TO ACCIDENT, PLEASE GIVE DETAILS	
20. .Date and Time of accident	(dd/mm/yyyy)
21. How did the accident happen?	
22. Was the Deceased suspected to be under the influence of any alcohol or drug	☐ Yes ☐ No
23. If yes, was three any sample of urine or blood sent for further test?	☐ Yes - Result _____ ☐ No
24. In your opinion / investigation, do you think that death resulted from the accident?	☐ Yes ☐ No
25. Was there any predisposing cause directly or indirectly to Deceased's death?	☐ Habits use of tobacco, alcohol, narcotics ☐ Family History ☐Occupation of Deceased ☐ HIV / AIDS

PAST MEDICAL HISTORY	
26. If the Deceased diagnosed of	**High Blood Pressure** Readings : _____mmHg Date : __ __/__ __/__ __ ___ __ Readings : _____mmHg Date : __ __/__ __/__ __ ___ __ **Diabetes** Readings : _____ (RBS/FBS) Date : __ __/__ __/__ __ ___ __ Readings : _____(RBS/FBS Date : __ __/__ __/__ __ ___ __

DETAILS OF OTHER ATTENDING DOCTORS WHO HAD TREATED THE DECEASED IN THE LAST TWO YEARS

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Treatment given

27. Any further information which in your opinion will assist us in assessing the claim	

DECLARATION:

I, the undersigned, do hereby declare the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company. Furthermore, I certify that I have personally examined the identity of the above-named Participant and the facts as stated above represent my medical opinion of his/her condition.

Name of the Attending Physician	Signature of the Attending Physician	Official Stamp and Address of Hospital / Clinic :
Date (dd/mm/yyyy)	Contact No.	