eTiQa Takaful

HOSPITALISATION & SURGICAL CLAIM- CLAIMANT'S STATEMENT
BORANG TUNTUTAN RAWATAN HOSPITAL & PEMBEDAHAN
KENYATAAN PIHAK YANG MENUNTUT

	Instruction ***Arahan*** Supporting documents required. *Dokumen sokongan yang diperlukan*
1.	Final itemised original bills and offical receipts covering hospitalisation and surgical expenses *Bil asal muktamad terperinci asal dan resit resmi yang mencatatkan perbelanjaan rawatan hospital dan pembedahan*
2.	Policy No. *No. Polisi*
3.	Life Assured details *Butir Hayat yang dilindungi* i. Name of Life Assured *Nama Asured* ii. I.C No. *No. Kad Pengenalan* iii. Age *Umur* iv. Occupation *Pekerjaan* v. Current correspondence address *Alamat Surat Menyurat Terkini* vi. Telephone No. *No. Telefon*
4.	Claimant's details (If other than life assured) *Butir Pihak Menuntut (jika berlainan daripada hayat yang dilindungi)* i. Name of claimant *Nama Pihak Menuntut* ii. I.C No. *No. Kad Pengenalan* iii. Correspondence address *Alamat Surat Menyurat* iv. Telephone No. *No. Telefon*
5.	If hospitalisation was due to accident, please furnish details of accident *Jika kemasukan ke hospital disebabkan kemalangan, sila beri butir kejadian kemalangan* i. When did it occur? DD MM YY at am / pm *Bila kemalangan tersebut berlaku? HH BB TT pada pagi / ptg* ii. Where did it occur? *Di mana kemalangan tersebut berlaku?* iii. How did it occur? *Bagaimana kemalangan tersebut berlaku?*

	iv. Nature and extent of injury *Jenis dan tahap kecederaan dialami*			
6.	If hospitalisation was due to other causes, please furnish *Jika kemasukan ke hospital akibat sebab-sebab lain, sila berikan butir* i. Nature of illness/ symptom *Jenis penyakit/simtom* ii. For how long had you/ the life assured been having the symptom prior to first admission? *Berapa lamakah anda/ hayat dilindungi telah menghidapi simtom sebelum pertama kali dimasukkan ke hospital?* iii. What was the diagnosis? *Apakah diagnosis ketika itu?*			
7.	Name and address of doctors who treated you/ the life assured for this illness/ injury/ condition *Nama dan alamat doktor yang merawat anda/hayat yang dilindungi bagi penyakit/ kecederaan /keadaan ini* i ii	Date of consultation *Tarikh rawatan*	Date of admission (if any) *Tarikh kemasukan (jika ada)*	
8.	Please furnish name and address of your/ the life assured's usual attending doctor other than above *Sila nyatakan nama dan alamat doktor yang selalu merawat anda/ hayat yang dilindungi, selain daripada yang di atas*			
9.	Are you / Is life assured presently insured for Hospitalisation & Surgical benefits under any Government law/ program, employee benefit, any health benefit scheme or any other insurance policy? If so, please furnish details *Adakah anda/ hayat yang dilindungi ketika ini di bawah perlindungan insurans faedah Hospital & Pembedahan, di bawah sebarang program/ undang-undang kerajaan, kemudahan pekerja, sebarang skim faedah kesihatan atau sebarang polisi insurans lain? Jika ada sila beri butir*			
	Name of Company/ Program /Scheme *Nama syarikat/ program/ skim*			
	Policy / membership No. *No. polisi/ keahlian*			
10.	**Declaration** I/ We hereby declare that the information given in this claim form are true and that I / the life assured did not suffer from any of the pre-existing conditions at the time of this policy was taken up. I further declare that the current confinement to the hospital is not due to any causes which are stipulated in the Exclusion Clause of the policy. I agree that in the event that I make, or have in the past made, any false or untrue statement and/ or suppressed and/ or concealed any materials facts in respect of my/ the life assured's health and condition, the company shall absolutely forfeit my/ the life assured's right to compensation and further reserves the right to recover any amounts paid earlier as a results thereof. ***Pengisytiharan*** *Saya/ Kami, dengan ini mengisytiharkan bahawa maklumat yang diberi dalam borang tuntutan ini adalah benar dan bahawasanya saya/ hayat yang dilindungi tidak menghidap sebarang penyakit ketika polisi ini dikuatkuasakan. Saya seterusnya mengisytiharkan bahawa kemasukan ke hospital kali ini bukan disebabkan keadaan yang dinyatakan dalam Fasal Pengecualian polisi.* *Saya bersetuju bahawasanya jika saya membuat atau pernah membuat sebarang kenyataan palsu atau tidak benar dan/ atau menghalang dan/atau menyembunyikan sebarang fakta matan berkaitan dengan kesihatan dan keadaan saya/ hayat dilindungi, syarikat akan secara mutlak berhak menarik balik hak saya/ hayat yang dilindungi untuk mendapat pampasan dan seterusnya mendapat hak untuk menuntut semula sebarang amaun yang telah dibayar sebelum ini.*			

Signature of Witness *Tandatangan Saksi*	Signature of life assured's *Tandatangan hayat dilindungi*
Name Nama	Date Tarikh
NRIC No. *No. Kad Pengenalan*	Signature of claimant *Tandatangan pihak menuntut*
Address *Alamat*	Date *Tarikh*

Authorization

I_____ NRIC No._____hereby authorize any physician, hospital, clinic or insurance company or other organization, institutions or persons, that have any records or knowledge of me/ the life assured or my/ life assured's health, to disclose to_____, or its representatives any and all such information and expressly waive on behalf of me/ the life assured or any person who has any claim or interest in any policy issued hereunder, all provisions of law forbiding any physician or surgeon from disclosing any information acquired while attending me/ the life assured in a professional capacity. This authorization shall irrevocably bind my successors and assigns and remain valid, notwithstanding my/ the life assured death or incapacity and a copy of this authorization shall be as effective and valid as the original

Kebenaran/ Pemberian Hak

Saya_____ No. kad pengenalan_____, dengan ini memberi kuasa kepada sebarang doktor, pihak hospital, klinik atau syarikat insurans atau lain-lain organisasi, institusi atau orang perseorangan yang mempunyai sebarang rekod atau pengetahuan tentang saya atau kesihatan saya, untuk mendedahkan kepada_____atau wakilnya tentang sebarang dan keseluruhan maklumat tersebut dan secara nyata menyisihkan hak bagi pihak diri saya/ hayat yang dilindungi atau sesiapa yang mempunyai sebarang tuntutan atau kepentingan dalam sebarang polisi yang dikeluarkan, ke atas semua peruntukan undang-undang yang melarang doktor atau pakar bedah daripada memberi sebarang maklumat yang diperoleh semasa merawat saya/ hayat yang dilindungi ketika mereka menjalankan tugas sebagai seorang profesional. Kebenaran ini mengikat dan tidak boleh dibatal oleh waris dan penerima serah hak dan akan kekal sah, tanpa mengira kematian atau ketidakupayaan saya/ hayat yang dilindungi dan salinan kebenaran ini dianggap sah dan berkesan seperti dokumen asal.

Signature of Witness *Tandatangan Saksi*	Signature *Tandatangan*
Name *Nama*	Relationship with patient *Hubungan dengan pesakit*
NRIC No. *No. Kad Pengenalan*	Date *Tarikh*

HOSPITALISATION CLAIM - ATTENDING PHYSICIAN'S STATEMENT

1. Patient's name .....

2. I/C No..... 3. Admission No. .....

4. Admission : Date/Time ..... 5. Discharge : Date/Time .....

6. If hospitalisation due to accident, please furnish

   a) Date and time of accident ..... b) Nature of accident .....

7. The date on which you first saw the patient for this illness/ injury/condition .....

8. Was the patient referred to your hospital by any doctor? If yes, please indicate his/ her name and address

   .....

9. What were symptoms the patient complained when he/she first saw you?

   .....

10. i) According to patient, how long had she/he been experiencing these symptoms?

    .....

    ii) How long do you feel these symptoms has lasted?

    .....

11. Had patient previously received any treatment for above symptoms? If so, please furnish name, address of doctors and dates of consultation .....

    .....

12. Have any investigation, test or procedure been performed? If so, please furnish a certified true copy of the result .....

13. What was your diagnosis? .....

14. Did you inform the patient the diagnosis? If so, when? .....

15. Nature of medical treatment given .....

16. For surgery:-

    a) Nature of operation performed .....

    b) Name of surgeon ..... c) Date surgery performed .....

17. Any possibility of patient having relapse? .....

18. Has the patient previously been treated or hospitalised in this or any other hospital for this or any other disease? Please state,

    Date ..... Disease/ Illness .....

    Hospital/Clinic .....

19. For female only a) Was the patient pregnant at time of hospitalisation? .....

    If so, for how many months?.....

    b) Was illness caused directly or indirectly by pregnancy/ child birth/caesarian section/ abortion miscarriage and all complications arising therefrom? .....

I hereby certify that the above answers are all true to the best of my knowledge.

Signature of doctor	Name & Practice stamp	Name & address of hospital / clinic

OPCLM12/AT/JUNE2008

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