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

Fax No. : …… E-mail Address : ……

If working, please state :

i) Present Occupation : ……

ii) Exact nature of occupation and duties : ……

iii) Name & address of employer : ……

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

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

Name of Claimant : ……

NRIC No.: ……..... Old IC No. : ……

Correspondence Address: ……

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

Fax 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)

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 Takaful Berhad or its representative any information that maybe 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.

Signature / Thumb print of Life Assured Stamp	Signature of Witness	Authorized Signature of Contract Holder & Company's
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 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 Takaful Berhad (266243D)
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