eTiQa Takaful

# TOTAL & PERMANENT DISABILITY CLAIM FORM (GROUP CLAIM)

## SECTION A

Every question must be fully answered. 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**

- ☐ Total and Permanent Disability Claim form
- ☐ Total & Permanent Disability Statement of Medical Examiner
- ☐ Original certificate
- ☐ Certified copy of Participant and/or Claimant's IC
- ☐ Letter of job termination from Participant's employer (if employed)
- ☐ Certified copy of clinic/ hospital consultation card
- ☐ Other supporting documents (if applicable)

Name of Participant ______________________

New IC No ______________________ Old IC No. ______________________ Age ______

Correspondence Address ______________________

______________________

Mobile Phone No. ______________________ E-mail address ______________________

Phone No. ______________________ Fax No. ______________________

What is the highest level of education do you have? ☐ Primary ☐ Secondary ☐ Tertiary ☐ Post graduate

1 Please list the jobs held in the past 3 years

| Dates (From -To) dd/mm/yyyy) | Job Title & Employer's Address | Exact Duties of Work | Average monthly income (RM) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

2 Name of the Employer prior to onset of disability ______________________

3 Address of Employer prior to onset of disability ______________________

______________________ Office Phone No. ______________________

4 Date of Employment ______________________ (dd/mm/yyyy)

5 Main duties prior to onset of disability ______________________

6 Work environment ☐ Factory ☐ Office ☐ Outdoors Type of industry ______________________

7 Are you in management or supervisory capacity? ______________________

8 Do you operate any machine or special equipments? ☐ Yes ☐ No

9 What is the qualification and/or skills needed for the job? ______________________

10 a. Any special skills required? ______________________

b. What is your normal working hours and days? ______________________

c. Are you required to work on shift, Sunday or on-call? ______________________

d. Any travelling (km/week) required by the job? ______________________

11 Condition/Disability due to Accident

a. When did the accident happen? Date: ______________ (dd/mm/yyyy) Time : ______________ (am/pm)

b. Where did the accident happen? ______________

c. What were you doing at the time of Accident? ______________

d. Describe in detail how the Accident happened ? ______________

______________

12 Condition/Disability due to Illness

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

______________

b. Date symptoms **first** commenced ______________ (dd/mm/yyyy)

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

d. Name & address of doctor you **first** consulted for this condition ______________

______________

e. What was the diagnosis? ______________

f. What treatment are you currently receiving? ______________

g. Have you previously sufferred from, or received treatment for a similar or related illness? ☐ Yes ☐ No

If yes, please give full details ______________

h. State the name and address of your regular doctor ______________

______________

i. Please give details of any other doctors you have consulted in connection with this or other conditions.

| Date of consultation (dd/mm/yyyy) | Date of admission (dd/mm/yyyy) | Date of discharge (dd/mm/yyyy) | Diagnosis | Name of doctor & address of hospitals/clinics |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

13 When were you last able to work? ______________ (dd/mm/yyyy)

14 What aspects of your disability prevent you from following your occupation/any occupation?

______________

______________

15 State the date when you are expected to resume your work and daily activities ______________ (dd/mm/yyyy)

16 Do you intent to seek another employment? ☐ Yes ☐ No

If yes, the nature of work ______________

If no, why? ______________

17 Employment termination date ______________ (dd/mm/yyyy)

18 Are there other policies in force on your life taken with other companies ? ☐ Yes ☐ No

i. If yes, please give details:

| Name of Company(s) | Commencement date (dd/mm/yyyy) | Contract no | Type of coverage | Sum assured |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

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

**Bank :** ______________________ **Bank Branch :** ______________________

**Bank Account Holder Name :** ______________________ **Bank Account no.:** ______________________

**Company Registration no :** ______________________ **(Eg:266243D)**

**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 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 Participant

Name ______________________

Date ______________________ (dd/mm/yyyy)

______________________

Signature / Thumb print of Claimant (if other than Participant)

Date ______________________

Full name ______________________

Contact No ______________________

Designation & Official stamp is required for Company or Bank:

______________________

Signature of Witness

Date ______________________

Full Name ______________________

NRIC No ______________________

Contact No ______________________

______________________

Authorised Signature of Contract Holder & Company's Stamp

Full name ______________________

Designation: ______________________

Contact No ______________________

Date ______________________

eTiQa Takaful

## 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 organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of employment, financial, health or medical history of myself ("the Particpant') and to provide such information to Etiqa Takaful Berhad or its authorised agents and/or employees.

I, agree, consent and allow Etiqa 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.

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 ______________________________ (dd/mm/yyyy)

______________________________

Signature of Contract holder (If Participant is a minor)

Name ______________________________

NRIC ______________________________

Old IC ______________________________

Tel No ______________________________

Date ______________________________ (dd/mm/yyyy)



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