MSIG Insurance (Malaysia) Bhd
Registration No. 197901002705 (46983-W)
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A member of MS&AD INSURANCE GROUP

NOTICE OF CLAIM (BORANG TUNTUTAN)
Critical Illness / Penyakit Kritikal

SECTION A – CLAIM INFORMATION – TO BE COMPLETED BY THE POLICYHOLDER AND THE PATIENT
SEKSYEN A – MAKLUMAT TUNTUTAN – UNTUK DI ISI OLEH PEMEGANG POLISI DAN PESAKIT

1. Full name of policyholder (Nama pemegang polisi) :

2. I/C No (No K/P) :

3. Occupation (Pekerjaan) :

4. Full address of policyholder (Alamat penuh pemegang polisi) :

Telephone No (No telefon) :

5. Policy No (No Polisi) :

Certificate of Insurance No (No Sijil Insurans) :

6. Patient's relationship to policyholder (Hubungan pesakit dengan pemegang polisi)

❑ Employee (Pekerja) ❑ Dependant (Tanggungan) ❑ Other – please describe (Lain-lain, sila nyatakan)

7. Full name of patient (Nama penuh pesakit) :

8. I/C No (No K/P) :

9. Occupation (Pekerjaan) :

10. Date of birth (Tarikh Lahir) : ❑ Male (Lelaki) ❑ Female (Perempuan)

11. Usual Country of Residence (Negara Kediaman Biasa) :

Nationality (Warganegara) :

12. State the nature of the injury, illness or medical condition (Nyatakan butir-butir kecederaan, penyakit dan situasi perubatan) :

13. On what dates did (Tarikh kejadian) :

(a) the symptoms first occur (tarikh simptom tersebut bermula)?

(b) the patient last work (tarikh terakhir pesakit bekerja)?

(c) the patient last consult the treating physician (tarikh terakhir pesakit berjumpa dengan doktor merawat)?

14. Does treatment relate to an accident (Adakah rawatan berkaitan dengan kemalangan)? ❑ Yes (Ya) ❑ No (Tidak)

If yes (jika ya): (a) what was the date of accident?
(bilakah tarikh kemalangan)

(b) give brief details of where and how the accident happened?
(nyatakan butiran ringkas mengenai di mana dan bagaimana kemalangan itu berlaku)

15. Name and address of usual doctor (Nama dan alamat doktor perubatan) :

Telephone No (No telefon) :

16. Has the patient consulted any doctor for the present or any related medical condition:
(Adakah pesakit berkonsultasi dengan mana-mana doktor berkenaan situasi perubatan yang berkaitan)

❑ Yes (Ya) ❑ No (Tidak)

If yes, for each doctor and hospital consulted, state name, full address and dates first consulted :
(Jika ya, bagi setiap doktor dan hospital yang dirujuk, nyatakan nama, alamat penuh dan tarikh kali pertama melawat)

17. If we require an independent medical examination (Jika kami memerlukan pemeriksaan perubatan bebas dilakukan)

(a) Where is the patient now located (Dimanakah pesakit berada sekarang) ?

(b) Who should be contacted to make the necessary arrangements (Siapakah yang harus dihubungi untuk membuat pengaturan yang diperlukan) ?

18. Give details of any other health insurance to which the patient may be entitled to claim :-
(Nyatakan butir-butir insurans kesihatan lain yang pesakit mungkin layak membuat tuntutan)

19. Have you already claimed under this Policy or any other policy?
(Adakah anda pernah membuat tuntutan dibawah polisi ini atau mana-mana polisi yang lain)

❑ Yes (Ya) ❑ No (Tidak)

If yes, please give brief details (Jika ya, sila nyatakan butir-butir ringkas) :

DECLARATION AND AUTHORIZATION

I declare that the answers given above are true and complete to the best of my knowledge and belief.
I understand the delivery of this form is in no way an admission of MSIG Insurance (Malaysia) Bhd's liability and payment to the hospital by MSIG Insurance (Malaysia) Bhd or its representative shall not be construed as final admission of MSIG Insurance (Malaysia) Bhd's liability and for this and any further claims arising, MSIG Insurance (Malaysia) Bhd reserves all rights for evaluation as appropriate.
I am fully aware of the limits as to my/Assured medical insurance under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same.
I hereby irrevocably authorize any organisation, institution, or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident/injury, to disclose to MSIG Insurance (Malaysia) Bhd or its representative such information. I agree that MSIG Insurance (Malaysia) Bhd or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including MSIG Insurance (Malaysia) Bhd's parent company, subsidiaries or any other associated companies within MSIG Insurance (Malaysia) Bhd's Group, reinsurers, medical examiners, claims investigators and industry association federations etc.) in relation to this claim. This authorization shall bind my/the Assured's/Insured's successors and assigns and remain valid notwithstanding my/Assured's/Insured's incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original. I agree the event I make, or have in the past made, any false or untrue statement and/or suppressed and/or concealed any material facts in respect of my/the insured's condition, MSIG Insurance (Malaysia) Bhd shall absolutely forfeit my/the Insured's/ Assured's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

PENGISYTIHARAN DAN PEMBERIKUASA

Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.
Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti MSIG Insurance (Malaysia) Bhd ini ke atas tuntutan saya/Asured dan saya bersetuju bahawa bayaran kepada hospital oleh MSIG Insurance (Malaysia) Bhd atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti MSIG Insurance (Malaysia) Bhd dan MSIG Insurance (Malaysia) Bhd berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.
Saya memahami sepenuhnya had-had insurans perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh insurans berkenaan.
Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/Asured/Insured, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada MSIG Insurance (Malaysia) Bhd atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan MSIG Insurance (Malaysia) Bhd atau wakilnya untuk mengguna dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak MSIG Insurance (Malaysia) Bhd atau MSIG Insurance (Malaysia) Bhd berkait dalam MSIG Insurance (Malaysia) Bhd, reinsurer, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/Asured/Insured dan kekal sah meskipun setelah kematian saya/Asured/Insured setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, MSIG Insurance (Malaysia) Bhd berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Signature of Patient (Tandatangan Pesakit)
Date (Tarikh) :

Signature of Policyholder (Tandatangan Pemegang Polisi)
Date (Tarikh) :

SECTION B – CLAIM INFORMATION – TO BE COMPLETED BY THE TREATING PHYSICIAN

1. How long have you been the patient's doctor?

2. How far back in time do your records go?

3. Please give the name and address of the referring physician

4. On what date were you first consulted for the injury, illness or medical condition concerned, or for any related condition:

5. What was the date of the patient's last consultation?

6. Please give your diagnosis of the injury/illness/condition:

7. Please give details of the treatment given or prescribed:

8. Please give a brief history of this or any related medical condition, and dates on which any previous consultations or treatment took place:

9. Do you have any reason to believe the patient is HIV positive or suffering any AIDS related condition?

10. If any accident is involved, how did it happen?

11. Please give details of your patient's smoking habits, both past and present:

12. Are you aware of any member of your patient's close family who have suffered from heart disease, stroke, diabetes, cancer, multiple sclerosis, or any other hereditary condition?

13. Have you any reason to believe the same or any related medical condition has been diagnosed or treated previously by any other doctor or hospital?

14. Please PRINT your name and address

Telephone No.:

_____ _____

Signature of treating physician

Physician's Rubber Stamp

Date:

OUR CHIEF MEDICAL OFFICER WOULD BE MOST GRATEFUL IF YOU COULD SEND ANY SPECIALIST OF HOSPITAL REPORTS, TOGETHER WITH ANY TEST, OR SIMILAR EVIDENCE TO SUPPORT THE VALIDITY OF YOUR PATIENT'S CLAIM.

1. The Company must be notified in writing promptly in the event of any claim or potential claim under the Policy.

2. The Policyholder and the patient and or his/her legal representatives must complete all questions in Section A of the Claim Form and sign it.

3. The treating Physician must complete all questions in Section B of the Claim Form, rubber stamp, date and sign it.

4. Incomplete Claim Forms cannot be accepted for processing of claim. Attach copies of all relevant documents.

5. Send the fully completed Claim Form, together with all relevant documents to the Company.

   Address correspondence to:

   Claims Department
   MSIG Insurance (Malaysia) Bhd. (197901002705 (46983-W))
   Level 17th, Menara Hap Seng 2,
   Plaza Hap Seng, No. 1 Jalan P. Ramlee
   50250 Kuala Lumpur.

P. O. Box 11034
50990 Kuala Lumpur
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Alor Setar
Tel: (604) 772 2266

Batu Pahat
Tel: (607) 433 6808

P. O. Box 320
30740 Ipoh
Tel: (605) 255 1319

P.O. Box 223
80720 Johor Bahru
Tel: (607) 208 7800

Klang
Tel: (603) 3343 6691

Kluang
Tel: (607) 772 6501

P. O. Box 63
15700 Kota Bharu
Tel: (609) 748 1280

P. O. Box 223
25720 Kuantan
Tel: (609) 515 7501

P. O. Box 483
75760 Melaka
Tel: (606) 289 4333

P. O. Box 612
10780 Penang
Tel: (604) 219 0800

Petaling Jaya
Tel: (603) 7954 4208

Seremban
Tel: (606) 601 3501

Sungai Petani
Tel: (604) 424 4180

Kota Kinabalu
Tel: (6088) 301 030

P. O. Box 308
93704 Kuching
Tel: (6082) 255 901

P. O. Box 310
98007 Miri
Tel: (6085) 434 890

P. O. Box 931
90710 Sandakan
Tel: (6089) 217 388

Sibu
Tel: (6084) 323 890

P. O. Box 784
91008 Tawau
Tel: (6089) 771 051