**MSIG Insurance (Malaysia) Bhd**
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# PRE-AUTHORISATION FORM / *BORANG PRA-KEBENARAN*

**Private and Confidential / *Sulit dan Persendirian***

**PART 1** (To be completed by Patient / Claimant)
**BAHAGIAN 1** *(Untuk diisi oleh Pesakit / Penuntut)*

1. Patient Name: *Nama Pesakit:*
2. NRIC (Old & New): *K.P. (Lama & Baru):*
3. a. Date of Birth: *Tarikh lahir:* b. Age: Umur: c. Sex: *Jantina:* ☐ Male *Laki-laki* ☐ Female *Perempuan*
4. Policy No. / Member ID/ Certificate No/ Plan/ Company Name : *No. Polisi / No. Ahli / No. Sijil / Pelan / Nama Syarikat:*
5. Admission / Planned Admission Date: *Tarikh kemasukan hospital:*
6. Hospital Name: *Nama Hospital:*
7. Name of Attending Doctor/ Speciality: *Nama Doktor yang merawat/ Kepakaran:*

**ADMISSION REASON (✓)** and answer accordingly
*Sila tanda (✓) dan jawab soalan yang berkenaan*

☐ 8. Accident: *Kemalangan:*
a. Occurred on: *Berlaku pada:* Date _____/_____/_____ *Tarikh* Time _____ *Masa* ☐ am *pagi* ☐ pm *petang*
b. Details of Accident: *Butir-butir kemalangan:*

☐ 9. Illness: *Penyakit:*
a. Symptoms first appeared on: *Tarikh simptom tersebut bermula:* Date _____/_____/_____ *Tarikh*
b. Doctor(s) consulted for this condition: *Doktor-doktor yang dilawati bagi penyakit ini:*
c. Doctor's or Clinic Contact (Address & Telephone): *Alamat & Telefon Doktor*

**GOODS AND SERVICES TAX (GST) INFORMATION / MAKLUMAT CUKAI BARANGAN DAN PERKHIDMATAN**
*Please tick (✓) and answer accordingly / Sila tanda (✓) dan jawab soalan yang berkenaan*

10. Are you GST registered? *Adakah anda berdaftar di bawah GST?* ☐ Yes/*Ya* ☐ No/*Tidak*
If "Yes", please provide your GST Registration Number: *Sekiranya "Ya", sila nyatakan nombor pendaftaran GST anda:*

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | |

**MSIG Insurance (Malaysia) Bhd** shall rely on the above information provided by you for tax credit purposes provided under the GST Act. **MSIG Insurance (Malaysia) Bhd** shall not be liable for any liability or any fine, charge or penalty as a result of relying on your incorrect advice. Should action be taken againts **MSIG Insurance (Malaysia) Bhd** and / or penalties be imposed on **MSIG Insurance (Malaysia) Bhd** by any tax authority for relying on the same, **MSIG Insurance (Malaysia) Bhd** reserves its right to be indemnified by you to the fullest extent permitted by law and any GST liability arising from your incorrect advice shall be payable by you.
***MSIG Insurance (Malaysia) Bhd*** *akan bergantung kepada maklumat yang anda berikan untuk kredit cukai yang diperuntukan di bawah Akta GST.* ***MSIG Insurance (Malaysia) Bhd*** *tidak bertanggungjawab terhadap sebarang liabiliti atau denda, penalti atau caj jika maklumat yang diberikan oleh anda tidak betul. Sekiranya tindakan dan / atau penalti dikenakan ke atas* ***MSIG Insurance (Malaysia) Bhd*** *oleh mana-mana pihak berkuasa,* ***MSIG Insurance (Malaysia) Bhd*** *berhak menuntut kerugian daripada anda sehingga tahap yang dibenarkan oleh undang-ungang dan sebarang liabiliti GST yang wujud berdasarkan maklumat yang tidak betul.*

11. 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 associations/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 rhis authorization shall be valid as the original. I agree that in 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* | Signature of Assured/ Claimant / *Tandatangan Pemilik Polisi /Penuntut* | Signature of Witness / *Tandatangan Saksi* |
|---|---|---|
| _____ | _____ | _____ |
| Full Name / *Nama Penuh:* | Full Name / *Nama Penuh:* | Full Name / *Nama Penuh:* |
| IC No. / *No. K.P:* | IC No. / *No. K.P:* | IC No. / *No. K.P:* |
| Date / *Tarikh:* | Date / *Tarikh:* | Date / *Tarikh:* |
| *Contact No. / No. untuk dihubungi:* | *Contact No. / No. untuk dihubungi:* | *Contact No. / No. untuk dihubungi:* |
| | Relationship to Patient / *Hubungan dengan pesakit* | |

NOTE: COMPLETION OF THIS PRE AUTHORISATION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
*NOTA: MELENGKAPKAN BORANG PERMINTAAN INI TIDAK SEMESTINYA MENJAMIN BAHAWA SURAT JAMINAN AKAN DIKELUARKAN.*

**PART 2 ADMISSION SECTION** ( To be completed upon admission by Doctor )

1. a. Patient name: b. NRIC: c. Age: d. Sex: ☐ Male ☐ Female

2. Policy No. / Member ID/ Certificate No/Plan/ Company No:

3. Admission No, / MRN and Hospital Name/ Hospital Contact and Fax No :

4. Admission Date and Time:

5. Expected days of stay / Discharge Date:

6. a. Symptoms / Conditions requiring admission:
   b. Patient's BP/ Temp/ Pulse:
   c. Date symptoms first appeared: _____/_____/_____
   d. How long is patient aware of conditions:
   e. Date first consulted: _____/_____/_____

7. a. Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No
   b. Was this patient referred? If Yes, please provide details below:
   c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed :

| Date: | Disease / Disorder: | Details of Treatment / Hospitalization: | Doctor / Hospital/ Clinic: |
|---|---|---|---|

   d. Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
   If no please provide reasons of admission :

8. a. ☐ Admitting Diagnosis:
   or
   b. ☐ Provisional Diagnosis:
   c. Diagnosis confirmed on: _____/_____/_____
   Advised patient on: _____/_____/_____
   d. Cause and pathology underlying the present diagnosis:
   e. Any possibility of relapse? ☐ Yes ☐ No

9. Estimated Total Costs : RM

10. Admission requires:
   ☐ Hospitalisation
   ☐ Day Care
   ☐ On Patient's Request

11. Is the illness / condition related to: (please tick (✓) if YES). Please provide details:
   a. ☐ Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage Or any complications arising therefrom.
   b. ☐ Congenital / Hereditary diseases
   c. ☐ Influence of Drugs / Alcohol
   d. ☐ Nervous / Mental / Emotional / Sleeping Disorder
   e. ☐ Cosmetic reason / Dental care / refractive errors correction
   f. ☐ AIDS / STD / VD/ HIV
   g. ☐ Self-inflicted injuries / Violation of laws / Strike / Riots
   h. ☐ None of the above

12. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):

13. Any other medical/surgical conditions present? ☐ No ☐ Yes, details below:
   a. _____ since: _____/_____/_____
   b. _____ since: _____/_____/_____

14. Was the patient pregnant at the time of hospitalization? (For Female Only)
   ☐ No ☐ Yes, _____ months

15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:
   b. Please indicate date/time of accident: (dd/mm/yy) _____/_____/_____ (hrs) _____ ☐ am ☐ pm

16. I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as stated above represent my medical opinion of his/her condition.

| Date | Name of Signature of Attending Doctor<br>DR's Contact no. and Email address | Doctor / Hospital Stamp |
|---|---|---|

**DISCHARGE SECTION** (To Be Completed Upon Discharge by Doctor)

17. Undertaking Letter Ref No: ( If available )

18. Date of Discharge:

19. a. Final Diagnosis:
   ICD code:
   b. Cause and pathology of the diagnosis:

20. Treatment given / Investigation done: ( Please supply copy of all investigation results ).

21. a. Surgical procedures performed:
   MMA code / PHFSR code:
   b. Date of surgery / procedure:

22. a. Recovery complication that arose (if any):
   b. In the case of DEATH, please advise Date/ Time and Cause of death :

23. I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as stated above represent my medical opinion of his/her condition.

| Date | Name of Signature of Attending Doctor | Doctor / Hospital Stamp |
|---|---|---|

# GIRO FUND TRANSFER / RENTAS FORM

[ Policy holders, Claimants ]

Please read the following instructions carefully before completing this form.

1. Type or write using BLOCK LETTERS.
2. Indicate **only one (1) preferred bank** account and **it should be active**.
3. Attach a **legible copy** of the top portion of the bank statement/relevant page of the savings account passbook which clearly indicates that the below mentioned account number belongs to you/your company.
4. Submission of this form shall not be construed as an admission of policy liability by the insurer.
5. This form will be utilized only in the event where the claim submitted is payable.

| | | | |
|---|---|---|---|
| 1 | Bank Account Holder Name | : | |
| 2 | Bank Name<br>(Interbank Giro Participating Banks) | : | |
| 3 | Bank Account Number | : | |

Please provide a relevant ID. The ID that you provide must be the same as appeared in your bank's record. Otherwise, the fund transfer will be REJECTED by your bank despite a correct bank account number. Eg. Your Business Registration number is 46983W and your banker's record is 046983W (with a zero in front).

| | | | |
|---|---|---|---|
| 4 | **RECIPIENT'S VALIDATION ID AS PER YOUR BANK'S RECORD** [ Indicate only one (1) and ignore dashes '-' ] | | |
| 4a | New IC Number | : | |
| 4b | Old IC Number | : | |
| 4c | Registration Number<br>(Company/Business/Society/etc) | : | |
| 4d | Police/Army/Passport Number | : | |

Payment Advice (Notification of Payment) is to be emailed to :-

| | | | |
|---|---|---|---|
| 5a | Email Address (1) | : | |
| 5b | Email Address (2) | : | |

I/We hereby request that payment(s) due to me/us by MSIG Insurance (Malaysia) Bhd ("MSIG") be paid to my/our bank account stated above by way of Giro Fund Transfer/Rentas and confirm that

1. I/We consent to MSIG processing and disclosing the above data to its banker(s) in order to facilitate payment(s) to me/us by way of Giro Fund Transfer/Rentas.
2. All information provided herein is correct and accurate.
3. My/Our request herein shall be irrevocable unless with the consent of MSIG (which shall not be unreasonably withheld). MSIG may at any time, provided there is a need to do so, in its reasonable discretion effect payment(s) to me/us by other mode(s).
4. I/We shall keep MSIG and its banker(s) indemnified against any loss and/or damage arising from this Giro Fund Transfer/Rentas provided always that the loss and/or damage is due to the gross negligence or willful default on my/our part which include but not limited to error in information furnished, delayed payment(s) and any other circumstances beyond MSIG and its banker(s)'s control and directly caused by me/us.

Authorised Signatory(ies)

Company Stamp (COMPULSORY for companies, businesses, societies, etc)

Name :
Designation :

MSIG - Office Use

Map the above details to the following client code(s) :

1. 2. 3.

BEC Prevention Validation Results :

| | | | | |
|---|---|---|---|---|
| MSIG's Staff Name : | | | Date : | |
| ☐ Validation Required (To complete details below) | | ☐ Validation Not Required | | |
| Contact Person Name : | | | Confirmation Date: | |
| Mode of Validation | ☐ Face-to-face | | | |
| | ☐ Contact | Contact Number : | ☐ Call | ☐ Text Message |
| | ☐ Fax | Fax Number : | | |
| | ☐ Others | Please specify : | | |