takafulmalaysia

SYARIKAT TAKAFUL MALAYSIA BERHAD (131646-K)
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FOR OFFICE USE		
FOR MCO PROCESSING	YES ☐	NO ☐
DATE RECEIVED:		
OFFICER IN-CHARGE:		
SERVICING BRANCH:		
CLAIM NUMBER:		

The issuance and acceptance of this claim form is not an admission of liability by the Company and if false statements or declarations be made in support of this claim, this claim shall be null and void. Please complete this claim form in CAPITAL LETTERS and cross [x] the boxes as appropriate.

Pengeluaran dan penerimaan borang tuntutan ini bukan pengakuan liabiliti oleh pihak Syarikat dan sekiranya kenyataan dan pengisytiharan palsu dibuat untuk menyokong tuntutan ini, maka tuntutan ini adalah dianggap batal dan tidak sah. Sila lengkapkan borang tuntutan ini dengan HURUF BESAR dan pangkah [x] pada kotak di mana perlu.

MEDICAL EXPENSES / DAILY CASH ALLOWANCE GROUP FAMILY TAKAFUL PLAN CLAIM FORM
BORANG TUNTUTAN BAGI PERBELANJAAN PERUBATAN / ELAUN TUNAI HARIAN PELAN TAKAFUL KELUARGA BERKELOMPOK

Part 1 / *Bahagian 1 :* Details of Claimant / *Butir-butir Pihak Yang Menuntut*

1. Name of Employer
Nama Majikan

Certificate Number / *Nombor Sijil*

2. Correspondence Address / *Alamat Surat-menyurat*

Postcode / *Poskod*

3. Telephone / *Telefon* 0 ☐ - ☐☐☐☐☐☐☐ Handphone / *Telefon Bimbit* 0 1 ☐ - ☐☐☐☐☐☐☐ Facsimile No / *No. Faksimili* ☐☐ - ☐☐☐☐☐☐☐☐

4. E-mail Address
Alamat E-mel

5. New IC No.
No. KP Baru ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐

Old IC No./Birth Certificate No./Passport No.
No. KP Lama/No. Sijil Kelahiran /No. Pasport

* 6. Name of Employee / *Nama Kakitangan* .....

Occupation
Pekerjaan .....

Date Employed (DD/MM/YYYY)
Tarikh Mula Bekerja (HH/BB/TTTT) ☐☐ - ☐☐ - ☐☐☐☐

Part 2 / *Bahagian 2 :* Details of Person with Illness or Injury / *Butir-butir Pihak Yang Menghidap Penyakit Atau Kecederaan*

1. Name / *Nama*

2. New IC No. / *No. KP Baru* ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐

Old IC No. /Birth Certificate No./Passport No.
No. KP Lama/No. Sijil Kelahiran /No. Pasport

3. The relationship between the person with illness or injury to the Employee. / *Hubungan antara pihak yang menghidap penyakit atau kecederaan dengan Pekerja*
.....

Part 3 / *Bahagian 3 :* Details of Illness or Injury / *Butir-butir Penyakit atau Kecederaan*

1. Exact diagnosis as certified by the attending doctor
Butir penyakit seperti yang disahkan oleh doktor yang merawat .....

2. Date when the symptom was first manifested (DD/MM/YYYY). /*Tarikh penyakit/kecederaan tersebut mula dikesan (HH/BB/TTTT)* ☐☐ - ☐☐ - ☐☐☐☐

3. Date of first consultation with a medical practitioner for this condition (DD/MM/YYYY)
Tarikh kali pertama mendapat rundingan dengan pegawai perubatan untuk penyakit/kecederaan ini (HH/BB/TTTT) ☐☐ - ☐☐ - ☐☐☐☐

4. Name, address and contact number of all medical practitioners that have been consulted for this condition
Nama, alamat dan nombor untuk dihubungi semua pegawai perubatan yang dirujuk untuk penyakit/kecederaan ini
.....
.....
.....

5. Is this condition related to pregnancy, abortion, miscarriage, sterilisation, sub-fertility, infertility, self-inflicted injury,sexually transmitted disease, congenital anomaly, nervous or mental disorder, cosmetic reasons or work-related injury, any drugs and alcohol abuse? If YES, please specify.
Adakah penyakit/kecederaan ini berkaitan dengan kehamilan, pengguguran, keguguran, kemandulan, kesuburan, ketidaksuburan, kecederaan yang disengajakan, penyakit kelamin, kecacatan sejak lahir, masalah mental, rawatan kosmetik atau kecederaan berkaitan pekerjaan? Jika YA, sila nyatakan.
☐ YES / *YA* ☐ NO / *TIDAK*
.....

* If applicable / *jika berkaitan*

Part 4 / *Bahagian 4 :* Details of Accident / *Butir-butir Kemalangan*

Please complete the following details if the illness/injury was due to accident. / *Sila lengkapkan butir-butir berikut sekiranya penyakit/kecederaan yang dialami adalah disebabkan oleh kemalangan.*

1. Date of accident (DD/MM/YYYY) / *Tarikh kemalangan (HH/BB/TTTT)* ☐☐ - ☐☐ - ☐☐☐☐ Time / *Masa* ☐☐ : ☐☐ AM / PM

2. Did the injured person suffer any injuries or disabilities of illness prior to this accident? If YES, please describe the nature of the injuries or disabilities or illness and the date it was first diagnosed.
Adakah pihak yang mengalami kecederaan juga telah mengalami sebarang kecederaan atau keilatan atau menghidap sebarang penyakit sebelum kemalangan tersebut berlaku? Jika Ya, terangkan dengan jelas jenis kecederaan atau keilatan atau penyakit yang dialami dan tarikh ianya mula diketahui.

.....

.....

.....

Part 5 / *Bahagian 5 :* Other Information / *Maklumat Lain*

Are you eligible to claim for this treatment against any other Insurance Policies/Takaful Certificate? / *Adakah anda layak menuntut rawatan ini di bawah Polisi Insuran/Sijil Takaful lain?*

If Yes, please state the Insurance Company/Takaful Operators.
Jika Ya, sila nyatakan nama Syarikat Insurans/Pengendali Takaful berkenaan. ☐ YES / *YA* ☐ NO / *TIDAK* .....

Part 6 / *Bahagian 6 :* Medical Information Authorisation / *Kebenaran Maklumat Perubatan*

I hereby authorise any hospitals, surgeons, medical practitioners or clinics or other persons who have attended or examined me or my dependent for any reasons to disclose any and all information with respect to any illnesses or injuries and to provide copies of all medical reports, including earlier medical history. A copy of this authorisation shall be considered as effective and valid as the original. /
Bahawasanya dengan ini, saya membenarkan mana-mana hospital, pakar bedah, pegawai perubatan atau klinik atau orang perseorangan lain yang pernah merawat atau memeriksa saya atau tanggungan saya atas apa jua sebab, untuk memberikan sebarang dan semua maklumat berkaitan penyakit atau kecederaan dan menyediakan salinan laporan perubatan termasuk sejarah perubatan terdahulu. Salinan kebenaran ini hendaklah juga dianggap sebagai sah sepertimana salinan asalnya.

☐☐ - ☐☐ - ☐☐☐☐
Date (DD/MM/YYYY)
Tarikh (HH/BB/TTTT)

.....
Signature of person with illness/injury or his/her guardian
Tandatangan pihak yang menghidap penyakit/kecederaan atau penjaganya

Part 7 / *Bahagian 7 :* Declaration by Employer and/or Certificate Owner / *Perakuan Majikan dan/atau Pemegang Sijil*

I/we hereby declare that, to the best of my/our knowledge, the above statements and facts are true and accurate and I/we did not falsify or provide any false statements to support this claim.
Bahawasanya dengan ini adalah saya/kami sepanjang pengetahuan saya/kami mengesahkan pernyataan-pernyataan dan butir-butir yang terkandung di atas adalah benar dan betul dan saya/kami tidak memalsukan atau memberikan pernyataan yang tidak benar bagi menyokong tuntutan tersebut.

If this form was completed by someone else, I/we hereby declare that all statements provided by them to be considered as statements provided by me/us and I/we shall be fully responsible for those statements.
Sekiranya borang ini diisi oleh orang lain bagi pihak saya/kami maka saya/kami mengaku bahawa semua pernyataan yang dibuat oleh mereka adalah disifatkan sebagai pernyataan saya/kami sendiri dan saya/kami akan bertanggungjawab ke atas pernyataan-pernyataan tersebut.

I/we also declare that I/we shall fully cooperate with the Company and any other parties representing the Company in relation to this claim.
Saya/Kami seterusnya mengaku akan memberi kerjasama yang sepenuhnya kepada pihak Syarikat serta mana-mana pihak lain yang mewakili pihak Syarikat bersabit dengan tuntutan ini.

I hereby authorize and direct Takaful Malaysia to reimburse any payable amount for this claim directly to :
Saya dengan ini membenar dan mengarahkan Takaful Malaysia membayar apa-apa manfaat yang layak kepada :

☐☐ - ☐☐ - ☐☐☐☐
Date (DD/MM/YYYY)
Tarikh (HH/BB/TTTT)

.....
Employer's/Certificate Owner's Signature (for Group Takaful Plan)
Tandatangan Majikan/Pemegang Sijil (untuk Pelan Takaful Berkelompok);
Sila letakkan Cop Rasmi jika berkenaan

.....
Employee's/Participant's Signature
Tandatangan Pekerja/Peserta

Part 8 / *Bahagian 8* : Details of Payees / *Butir-butir Pihak Yang Menerima Bayaran*

Please complete the following details if the payment is to be made to beneficiary / *Sila lengkapkan butir-butir berikut sekiranya bayaran dibuat ke atas waris.*

1. Name / *Nama*

2. New NRIC No. / *No. KP Baru* ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC No./Passport No./Company Reg. No. / *No. KP Lama/No. Pasport/No. Pendaftaran Syarikat* ☐☐☐☐☐☐☐☐☐☐☐☐

3. Relationship to the deceased / *Hubungan dengan pihak yang meninggal dunia* _____

Part 9 / *Bahagian 9* : Verification of Identity / *Pengesahan Pengenalan*

I hereby certify that the original NRIC / Company Registration Certificate of the Participant and Claimants were verified and authenticated by me at the point of claim submission.
Saya dengan ini mengesahkan bahawa salinan asal kad pengenalan KP / Sijil Pendaftaran Syarikat peserta dan pihak yang menuntut telah disahkan oleh saya ketulenannya ketika permohonan tuntutan dibuat.

Third Party Verification / *Pengesahan Pihak Ketiga* :

Signature / *Tandatangan* .....

New IC No. / *No. KP Baru* ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐

Name / *Nama* .....

Date (DD/MM/YYYY)
Tarikh (HH/BB/TTTT) ☐☐ - ☐☐ - ☐☐☐☐

"Third Party" means takaful agents, takaful brokers or staff of the Company . / *"Pihak Ketiga" bermaksud ejen takaful, broker takaful atau kakitangan pihak Syarikat.*

Important Notice / *Notis Penting*

Please submit the following documents to support your claim: / *Sila sertakan dokumen-dokumen di bawah untuk menyokong tuntutan anda:*

- ☐ Medical Expences / Daily cash allowance claim form For Group Takaful Plan
  Borang Tuntutan Bagi Perbelanjaan Perubatan untuk Elaun tunai harian Pelan Takaful Keluarga Berkelompok
- ☐ Certified true copy of Identity Card of the person with illness/injury
  Salinan Kad Pengenalan pihak yang menghidap penyakit/kecederaan yang disahkan
- ☐ Original medical bills and itemized billing
  Bil-bil asal perbelanjaan perubatan dan bil terperinci
- ☐ Original medical receipts
  Resit-resit asal perbelanjaan perubatan
- ☐ Copy of discharge note or copy of medical bill for Daily cash allowance only
  Salinan nota discaj atau salinan bil-bil perbelanjaan perubatan untuk Elaun Tunai Harian sahaja

Additional document for illness/injury due to accident
Dokumen tambahan bagi penyakit/kecederaan akibat kemalangan

- ☐ Certified true copy of Police Report
  Salinan Laporan Polis yang disahkan

Additional documents for Group Family Takaful Plan
Dokumen tambahan bagi Pelan Takaful Keluarga Berkelompok

- ☐ Proof of membership e.g. members list, endorsement etc.
  Bukti penyertaan seperti senarai nama, endosmen dll.
- ☐ Proof of relationship between member/employee of the participant and the person with illness/injury if he/she was not a member/employee of the participant
  Bukti hubungan ahli/kakitangan peserta dengan pihak yang menghidap penyakit/kecederaan sekiranya beliau bukanlah ahli/kakitangan peserta
- ☐ Certified copy of payees Identity Card - if payment is to be made to beneficiary
  Salinan Kad Pengenalan sekiranya pembayaran di buat ke atas waris yang disahkan

Please note that the Company may require additional supporting documents to be submitted after the claim has been registered. / *Sila ambil maklum bahawa pihak Syarikat mungkin memerlukan dokumen-dokumen tambahan lain untuk diserahkan setelah tuntutan ini didaftarkan.*

Direct Credit Instruction / *Arahan Pindahan Terus*

Important Note : The account holder name and claimant must be the same person / ***Nota Penting :*** *Nama Pemegang Akaun dan penandatangan arahan kredit mestilah sama dengan penuntut pada borang tuntutan.*

E-Payment (Company) / *E-Pembayaran (Syarikat)*

Company Name / *Nama Syarikat*	
Company Registration No. / *No. Pendaftaran Syarikat*	
Address / *Alamat*	
Contact Person / *Pegawai Dihubungi*	
E-mail Address / *Alamat E-mel*	
Bank Name / *Nama Bank*	
Bank Account No. / *No. Akaun Bank*	
SWIFT Code / *Kod SWIFT*	

Terms and Conditions / *Terma-terma dan syarat-syarat*

1. Please furnish a copy of the bank statement for verification purpose.
   Sila kemukakan satu salinan penyata bank untuk tujuan pengesahan.
2. If the copy of bank statement is not provided, the Company is deemed to have confirmed the account details provided in this form as valid and accurate.
   Jika salinan penyata bank tidak dikemukakan, Syarikat dianggap telah mengesahkan bahawa butir-butir akaun di dalam borang ini adalah sahih dan tepat.
3. In the event of any invalid / inaccurate account details provided by the Company results in payment being credited into a third party bank account or if there is any loss incurred, the payment made thereto is still deemed as full payment and Takaful Malaysia shall be released and fully discharged from all existing and future liabilities, claims and demands in relation to such payment.
   Sekiranya butir-butir yang diberikan oleh Syarikat tidak sah atau tidak tepat, mengakibatkan pembayaran Kredit Terus ke dalam akaun bank pihak ketiga atau sebarang kerugian, pembayaran dibuat itu masih dianggap pembayaran penuh dan Takaful Malaysia tidak akan bertanggungjawab atas segala liabiliti, dakwaan dan permintaan pada masa kini dan juga pada masa hadapan yang berkaitan dengan pembayaran tersebut.

Authorized Signatory /
Penandatangan Yang Dibenarkan

Name / *Nama* :
Designation / *Jawatan* :
Date / *Tarikh* :

Company Stamp / *Cop Syarikat*

MEDICAL CERTIFICATION OF TREATMENT

THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN. Please use separate sheet of paper if additional space is required.

A. GENERAL INFORMATION

1. Name of patient ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MRN No : ....

New IC No. ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC No/Birth Certificate No/Passport No ☐☐☐☐☐☐☐☐☐☐☐☐

2. Period of hospitalisation	Admission (DD/MM/YYYY) ☐☐ - ☐☐ - ☐☐☐☐ Discharged (DD/MM/YYYY) ☐☐ - ☐☐ - ☐☐☐☐
3. Primary diagnosis	
4. Etiology of the above diagnosis	
5. Date you were first consulted for the above condition (DD/MM/YYYY)	☐☐ - ☐☐ - ☐☐☐☐
6. Other diagnosis presented and date first diagnosed (DD/MM/YYYY)	☐☐ - ☐☐ - ☐☐☐☐
7. Presenting SYMPTOMS at time of first consultation / Date of onset (DD/MM/YYYY)	☐☐ - ☐☐ - ☐☐☐☐
8. Any risk factor contributed to the above condition?	
9. Is the patient's condition related to pregnancy, abortion, miscarriage, sterilisation, sub-fertility, infertility, self-inflicted injury, sexually transmitted disease, congenital anomaly, nervous or mental disorder, cosmetic reasons or work-related injury, drugs and alcohol abuse ? If YES, please specify.	☐ YES ☐ NO ------------------------------

B. MEDICAL HISTORY

1. Has the patient ever been treated previously for this condition? If YES, please state exact date. (DD/MM/YYYY)	☐ YES ☐ NO ☐☐ - ☐☐ - ☐☐☐☐
2. Approximately, when did the patient first became aware of the condition? (DD/MM/YYYY)	☐☐ - ☐☐ - ☐☐☐☐
3. In your professional opinion, when did the condition first develop. (DD/MM/YYYY)	☐☐ - ☐☐ - ☐☐☐☐

4. Other medical practitioners previously consulted by the patient for this condition:

Name	Consultation Date (DD/MM/YYY)	Address & contact number
------------------------------	☐☐ - ☐☐ - ☐☐☐☐	------------------------------
------------------------------	☐☐ - ☐☐ - ☐☐☐☐	------------------------------
------------------------------	☐☐ - ☐☐ - ☐☐☐☐	------------------------------

5. Has Patient SUFFERED from / Is Patient SUFFERING any illnesses stated below?

Hypertension	☐ YES	☐ NO	since :	Name & Address of Referring Physician (if any)
Cardiovascular Disease	☐ YES	☐ NO	since :	....
Gastrointestinal Disease	☐ YES	☐ NO	since :	....
Malignancy of Any Kind	☐ YES	☐ NO	since :	
Diabetes	☐ YES	☐ NO	since :	....
Others	☐ YES	☐ NO	since :	Please specify : ....

C. DETAILS OF SURGICAL OPERATIONS AND/OR PROCEDURES PERFORMED

Type of Operation / Procedure	Date Performed	Performed By
------------------------------	☐☐ - ☐☐ - ☐☐☐☐	------------------------------
------------------------------	☐☐ - ☐☐ - ☐☐☐☐	------------------------------
------------------------------	☐☐ - ☐☐ - ☐☐☐☐	------------------------------
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D. DECLARATION BY THE ATTENDING PHYSICIAN

To the best of my knowledge, I hereby declare that all the information given above are true and accurate.

Signature of Attending Physician : .... Professional Qualifications : ....

Name : ....

Official Seal : Date (DD/MM/YYYY) : ☐☐ - ☐☐ - ☐☐☐☐