TAKAFULmalaysia

HEAD OFFICE/ *IBU PEJABAT:*

Syarikat Takaful Malaysia Keluarga Berhad (131646-K)
14th Floor, Annexe Block, Menara Takaful Malaysia,
No 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur,
P.O. Box 11483, 50746 Kuala Lumpur

W takaful-malaysia.com.my
T 1-300 88 252 385
F 603-22740237
E csu@takaful-malaysia.com.my

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 BENEFIT/DAILY CASH ALLOWANCE CLAIM FORM
BORANG TUNTUTAN BAGI MANFAAT PERBELANJAAN PERUBATAN/ELAUN TUNAI HARIAN

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

1. Name of Employer (for Group Plan) or Participant (for Individual Plan)
Nama Majikan (Untuk Pelan Berkelompok) atau Peserta (Untuk Pelan Individu)

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 (for Group Plan) / *Nama Kakitangan (untuk Pelan Berkelompok)* .....

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 and the Employee (for Group Plan) or Participant (for Individual Plan). /*Hubungan antara pihak yang menghidap penyakit atau kecederaan dan Pekerja (untuk Pelan Berkelompok) atau Peserta (untuk Pelan Individu)* .....

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 Certificate Owner / *Perakuan Pemegang Sijil*

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

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

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

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

……..
Participant's Signature / *Tandatangan Peserta*

Part 8 / *Bahagian 8 :* 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*:

- ❑ Hospital and Surgical benefit / Daily cash allowance claim form duly completed
  Borang Tuntutan Bagi Manfaat Hospital dan Pembedahan / Elaun Tunai Harian yang lengkap diisi
- ❑ Certified true copy of Participant's Identity Card
  Salinan Kad Pengenalan yang disahkan
- ❑ 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

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 (Individual) / *E-Pembayaran (Individu)*

Name of Account Holder / *Nama Pemegang Akaun*	
Mykad No. / Passpoprt No. / *No. Mykad / Pasport*	
Correspondence Address / *Alamat Surat Menyurat*	
E-mail Address / *Alamat E-mel*	
Telephone No. / *No. Telefon*	
Bank Name / *Nama Bank*	
Bank Account No. / *No. Akaun Bank*	
Signature / *Tandatangan*	Date / *Tarikh*

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

1. Direct Credit facility is only applicable for bank accounts maintained in Malaysia. For overseas customers, we will assess and allow overseas accounts on a case to case basis.
   Kemudahan Kredit Terus hanya boleh digunakan bagi akaun bank yang diselenggara di Malaysia sahaja. Bagi pelanggan luar negara, kami akan menilai setiap kes sebelum membenarkan kemudahan Kredit Terus ini.
2. Direct Credit facility is applicable for Participant's / Certificate Owner's bank account only. Payment to other beneficiaries is to be considered on case by case basis.
   Kemudahan Kredit Terus Boleh digunakan untuk akaun bank Peserta / Pemilik Sijil sahaja. Pembayaran kepada penerima lain akan dipertimbangkan berdasarkan setiap kes.
3. Participant / Certificate Owner is to furnish a copy of the bank passbook or bank statement and the IC no. / Passport no. that was used to open the bank account for verification purpose.
   Peserta / Pemilik Sijil perlu mengemukakan satu salinan buku simpanan bank atau penyata bank dan No. Kad Pengenalan / No. Pasport yang digunakan bagi membuka akaun bank untuk tujuan pengesahan.
4. If the copy of bank passbook or bank statement is not provided, the Participant / Certificate Owner is deemed to have confirmed the account details provided in this form as valid and accurate.
   * In the event of any invalid / inaccurate account details provided by Participant / Certificate Owner results in payment being credited into a third party bank account, the payment made thereto is still deemed as full payment for Refund / Surrender/ Partial Withdrawal / Claims /Cancellation/ Others and STMKB shall be released and fully discharged from all existing and future liabilities, claims and demands in relation to such Refund / Surrender / Partial Withdrawal / Claims / Cancellation / Others.

   Jika salinan buku simpanan bank atau penyata bank tidak dikemukakan, Peserta / Pemilik Sijil dianggap telah mengesahkan bahawa butir-butir akaun di dalam borang ini adalah sahih dan tepat.
   * *Sekiranya butir-butir yang diberikan oleh Peserta / Pemilik Sijil tidak sah atau tidak tepat, mengakibatkan pembayaran Kredit Terus ke dalam akaun bank pihak ketiga, pembayaran dibuat itu masih dianggap pembayaran penuh bagi tujuan Bayaran Balik / Serahan / Pengeluaran Sebahagian / Tuntutan / Pembatalan / Lain-lain dan STMKB tidak akan bertanggungjawab atas segala liabiliti, dakwaan dan permintaan pada masa kini dan juga pada masa hadapan yang berkaitan dengan Bayaran Balik / Serahan / Pengeluaran Sebahagian / Tuntutan / Pembatalan / Lain-lain.*

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. / *No KP Baru* ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC No/Birth Certificate No/Passport No / *No KP Lama/No Sijil Kelahiran/No Pasport* ☐☐☐☐☐☐☐☐☐☐☐☐

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
.....	☐☐ - ☐☐ - ☐☐☐☐	.....
.....	☐☐ - ☐☐ - ☐☐☐☐	.....
.....	☐☐ - ☐☐ - ☐☐☐☐	.....
.....	☐☐ - ☐☐ - ☐☐☐☐	.....

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 : ..... Date (DD/MM/YYYY) : ☐☐ - ☐☐ - ☐☐☐☐