TAKAFULmalaysia

Individual Medical Claim Form

IMPORTANT NOTE :

1. One form for ONE admission and pre and post hospitalisation visit.
2. Claim for hospitalisation and surgical expenses must be submitted within 30 days from the date of discharge or consultation visit.
3. For Overseas Treatment, kindly include original detailed admission bill showing details of each charges, original receipt and medical report. If the bills is in foreign language, kindly provide english translation.
4. For excess amount to be claimed from first Takaful Operator/Insurer, to provide claim worksheet / settlement with all the supporting documents and must be Certified True Copy (CTC) from the first Takaful Operator/Insurer. The CTC is not applicable for the original receipt paid by claimant.

CHECKLIST ON SUBMISSION OF CLAIM DOCUMENTS

☐ **Hospitalisation / Daycare Treatment**	☐ **Pre and Post Hospitalisation**	☐ **Accidental Claim**
1. Original receipt (deposit and final payment).	1. Original receipt (deposit and final payment).	1. Original receipt (deposit and final payment).
2. Original bill and itemised bill.	2. Original bill and itemised bill.	2. Original bill and itemised bill.
3. Medical report / section II of this form.	3. Copy of investigation report (lab / imaging).	3. Medical report / section II of this form.
4. Copy of investigation report (lab / imaging).	4. Referral letter (if any).	4. Copy of investigation report (lab / imaging).
5. Referral letter (if any).	5. Physiotherapy details - visit date and amount for each treatment session done / appointment card (advance payment NOT accepted).	5. Referral letter (if any).
6. Discharge note for Daily Cash Allowance at Government Hospital.		6. Copy of police report / driving license for road traffic accident.

SECTION I – To be completed by the Participant / Person Covered (Patient) (IN BLOCK LETTERS)
Remarks: All fields marked with (*) are compulsory.

A. PARTICIPANT INFORMATION

1. * Name of Participant (as in NRIC)

2. * NRIC No. / Passport No. ____ – ____ – ____

3. Certificate No.

4. Product Name

5. * Mobile No. ____ – ____

6. Gender ☐ Male ☐ Female

7. * Email Address

B. PERSON COVERED (PATIENT) INFORMATION

☐ The Person Covered is the same person as the Participant.

1. * Name of Person Covered (as in NRIC)

2. * NRIC No. / Passport No.

3. Gender ☐ Male ☐ Female

C. IF HOSPITALISATION / INJURY DUE TO ACCIDENT

1.	Date and Time of Accident :	
2.	Place of Accident & How Did the Accident Occur :	

D. DECLARATION AND AUTHORISATION

1. I declare that the information given above are true and complete to the best of my knowledge and belief.
2. I understand the delivery of this form is in no way an admission of Syarikat Takaful Malaysia Am Berhad's (hereinafter referred to as the "Company") liability and payment to the hospital by the Company or its representative shall not be construed as final admission of the Company's liability and for this and any further claims arising. The Company reserves all rights for evaluation as appropriate.
3. I am fully aware of the limits under the above-mentioned certificate. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said certificate, or that is not covered by the same.
4. 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 injury/illness, to disclose to the Company or its representative such information. This authorization shall bind my successors and assigns and remain valid notwithstanding my/Person Covered's death or incapacity in so far as legally possible. A photocopy of this 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 Person Covered's condition, the Company shall absolutely forfeit my/the Person Covered's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.
5. I have read and understood the Privacy Notice made available on the Company's website at www.takaful-malaysia.com.my. I agree that any of my personal information collected or held by the Company (whether contained in this form or otherwise obtained) ("my personal information") may be held, used, and disclosed by the Company to individuals or organisations related to or associated with the Company or any selected third party (within or outside of Malaysia, including retakaful and claims investigation companies and industry associations/federations) for the purpose of processing this claim application and providing subsequent service for the certificate, in the manner set out in the said Privacy Notice. I understand that I have the right to obtain access to and to request correction of any of my personal information by contacting Company's Customer Service at 1-300 88 252 385 or email to csu@takaful-malaysia.com.my.

Signature of Participant

Date

E. DIRECT CREDIT INSTRUCTION

1.	Bank Name	Important Note: 1. By default, approved claims payments will be credited into the Participant's Bank Account. 2. If no bank account information is provided earlier, kindly provide the Company such information which will be treated as new enrolment of account number for this claim and future transactions. 3. The account holder name and claimant must be the same person.
2.	Bank Account Holder Name	
3.	Bank Account No.	
4.	Terms and Conditions 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. 2. Direct Credit facility is applicable for the Participant's bank account only. Payment to other beneficiaries is to be considered on case by case basis. 3. The Participant is to furnish a copy of the bank passbook or bank statement and the NRIC no. / Passport no. that was used to open the bank account for verification purpose. 4. If the copy of bank passbook or bank statement is not provided, the Participant 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 the Participant 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 the Company 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.	

SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS) – Please answer all questions

1.	a) Patient Name	b) NRIC No.	c) Age	d) Gender
2.	Admission Date and Time D D / M M / Y Y Y Y : (hrs)	3. Dicharge Date D D / M M / Y Y Y Y		
4.	a) Symptoms / Conditions requiring admission	b) How long is patient aware of the condition:		
	c) Patient's BP / Temp / Pulse:			
	d) Date symptoms first appeared:	e) Date first consulted:		
5.	a) Admitting Diagnosis: c) Diagnosis confirmed on: D D / M M / Y Y Y Y Advised patient on: D D / M M / Y Y Y Y	b) Cause and pathology underlying the present diagnosis: i) ii) iii) d) Any possibility of relapse: ☐ Yes ☐ No		
6.	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: 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 / Hospitalisation / Doctor / Hospital / Clinic d) Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No If No, please provide reasons of admission:			
7.	Any other medical / surgical conditions present? ☐ No ☐ Yes, details below: a)_____ since D D / M M / Y Y Y Y b)_____ since D D / M M / Y Y Y Y			
8.	Final Diagnosis / ICD Coding i) ii) iii)	b) Cause and pathology of the diagnosis		
9.	Treatment given / Investigation done (Please supply copy of all investigation results): D D / M M / Y Y Y Y			
10.	a) Surgical procedures performed: Malaysian Medical Association (MMA) Code:	Date of surgery / procedure:		
11.	Treatment given / Investigation done (Please supply copy of all investigation results): a) ☐ Childbirth / Infertility / Caesarean Section / Miscarriage or any Complications b) ☐ Congenital / Hereditary Disease 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.	Was the patient pregnant at the time of hospitalization? (For Females Only) ☐ No ☐ Yes, _____months			
13.	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. Name & Signature of Attending Doctor / Doctor / Hospital Stamp / Date			