TAKAFULmalaysia

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FOR OFFICE USE	
MASTER CLAIM FORM 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.

DISABILITY CLAIM FORM FOR GROUP FAMILY TAKAFUL PLAN / *BORANG TUNTUTAN KEILATAN PELAN TAKAFUL KELUARGA BERKELOMPOK*

Part 1 / *Bahagian 1* : Details of the Person with Disability / *Butir-butir Pihak Yang Mengalami Keilatan*

Certificate Number / *Nombor Sijil*

1. Name / *Nama*

2. New NRIC No. / *No. KP Baru* [ ][ ][ ][ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Old IC No./ Birth Certificate No./ Passport No./ *No. KP Lama / No.Sijil Kelahiran / No. Pasport* [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

3. If this person is not the participant/member/employee of the participant, please state his/her relationship to the participant/member/employee of the participant / *Sekiranya pihak yang mengalami keilatan bukanlah peserta/ahli/kakitangan peserta, sila nyatakan perhubungan beliau dengan peserta/ahli/kakitangan peserta* _____

4. Type of disability / *Jenis Keilatan*
☐ Permanent Total Disability / *Jenis Keilatan Sepenuhnya*
☐ Permanent Partial Disability / *Keilatan Kekal Sebahagian*
☐ Temporary Total Disability / *Keilatan Sementara Sepenuhnya*
☐ Temporary Partial Disability / *Keilatan Sementara Sebahagian*

5. Date of onset of the disability (DD/MM/YYYY) / *Tarikh keilatan mula dialami (HH/BB/TTTT)* [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

6. Primary cause of disability / *Sebab utama keilatan*
☐ Accident / *Kemalangan*
☐ Illness / *Penyakit*

7. Details of disability as confirmed by the attending physician/ *Maklumat keilatan sebagaimana yang disahkan oleh pegawai perubatan yang merawat* _____

8. Name of attending physician, hospital and address/ *Nama pegawai perubatan yang merawat, hospital dan alamat* _____

Part 2 / *Bahagian 2* : Details of Accident / *Butir-butir Kemalangan*

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

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

2. Please describe in your own words the nature and extent of the injuries suffered due to this accident and medical treatment received. Please do not state "Please refer to the Police Report" or "Please refer to the Medical Report". / *Dengan perkataan anda sendiri, terangkan kecederaan yang dialami akibat kemalangan tersebut serta nyatakan rawatan yang telah diterima. Sila jangan nyatakan "Sila rujuk kepada Laporan Polis" atau "Sila rujuk kepada Laporan Perubatan" di dalam penerangan anda.*

_____
_____
_____

3. Did the injured person suffer any injuries or disabilities or 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 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 3 / *Bahagian 3* : Details of Illness / *Butir-butir Penyakit*

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

1. Cause of disability as certified by the attending doctor / *Sebab keilatan yang disahkan oleh doktor yang merawat* _____

2. Date when the symptom was first diagnosed (DD/MM/YYYY) / *Tarikh penyakit tersebut mula dikesan (HH/BB/TTTT)* [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

3. Date of first hospital admission (DD/MM/YYYY) / *Tarikh kali pertama dimasukkan ke hospital (HH/BB/TTTT)* [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Part 4 / *Bahagian 4* : Details of Medical Treatment / *Butir-butir Rawatan Perubatan*

Please state summary of the medical treatment received related to the disability / *Sila nyatakan maklumat rawatan perubatan yang diterima berkaitan keilatan yang dialami.*

Hospital's name and location / *Nama Hospital dan lokasi*	Date of admission / *Tarikh dimasukan ke hospital*	Date of discharged / *Tarikh keluar dari hospital*	Full description of diagnosis / *Diagnosa yang sepenuhnya*

Part 5 / *Bahagian 5* : Details of Medical Leave / *Butir-butir Cuti Sakit*

1. Date entitled for medical leave / *Senaraikan tarikh-tarikh anda diberikan cuti sakit* _____

2. Date entitled for light duty leave / *Senaraikan tarikh-tarikh anda diberikan cuti kerja ringan* _____

3. Date when the employment was terminated (DD/MM/YYYY), if applicable / *Tarikh ditamatkan perkhidmatan (HH/BB/TTTT), Sekiranya berkenaan* [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Part 6 / *Bahagian 6* : Details of Claimant / *Butir-butir Pihak Yang Menuntut*

Please complete the following details if the claimant is other than the Participant / *Sila lengkapkan butir-butir berikut sekiranya penerima bayaran manfaat selain daripada Peserta.*

1. Name / *Nama*

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

Part 7 / *Bahagian 7* : Medical Information Authorisation / *Perakuan Peserta dan/atau Pihak Yang Menuntut*

I hereby authorise any hospitals, surgeons medical practitioners or clinics or other persons who have attended or examined me or my child 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 original. /
Bahawasanya dengan ini, adalah saya/kami memberankan mana-mana hospital, pakar bedah, pegawai perubatan atau klinik atau orang perseorangan lain yang pernah merawat atau memeriksa saya atau anak 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 disability or his/her guardian / *Tandatangan pihak yang mengalami kelatan atau penjaganya* _____

Part 8 / *Bahagian 8* : Declaration by Participant and Claimant / *Perakuan Peserta dan/atau Pihak Yang Menuntut*

I/We hereby declare that to the best of my/our knowledge, the above statements and facts are true 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 yang terkandung di atas adalah benar dan betul dan saya/kami tidak memalsukan atau memberikan pernyataan yang tidak benar bersabit 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 mengaku bahawa apa-apa pernyataan yang dibuat oleh mereka adalah disifatkan sebagai pernyataan saya/kami sendiri dan saya/kami mengaku bertanggungjawab dengan pernyataan-pernyataan tersebut.

I/We also declare that 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 penuh dan sepatutnya 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* (Please affix Official Seal, if applicable) / *(Sila letakan Cop Rasmi jika berkenaan)* _____

Claimant's Signature / *Tandatangan Pihak Yang Menuntut* _____

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

I hereby certify that the participant's and claimant's original NRIC / Company Registration Certificate was 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 kesulenannya ketika permohonan tuntutan dibuat.*

Third Party Verification / *Pengesahan Pihak Ketiga:*

Signature / *Tandatangan* _____

Name / *Nama* _____

New NRIC No. / *No. KP Baru* ____ - ____ - ____

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 yang menyokong tuntutan anda*

- ☐ Disability Claim Form For Group Family Takaful Plan / *Borang Kelatan Untuk Pelan Takaful Keluarga Takaful Berkelompok*
- ☐ Certified copy of Medical Report / *Salinan Laporan Perubatan yang disahkan, sekiranya ada*
- ☐ Certified copy of Identity Card of the person with disability / *Salinan Kad Pengenalan pihak yang mengalami kelatan yang disahkan*

Additional document for disability due to accident / *Dokumen tambahan bagi kelatan akibat kemalangan*

- ☐ Certified 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 disability if he/she was not a member/employee of the participant / *Bukti hubungan ahli/kakitangan ahli/kakitangan peserta dengan pihak yang mengalami kelatan sekiranya beliau bukanlah ahli/kakitangan peserta*

Additional documents for group family takaful plan (credit card) / *Dokumen tambahan bagi pelan takaful keluarga berkelompok (kad kredit)*

- ☐ Certified copy of payees Identity Card - if payment is to be made to beneficiary / *Salinan Kad Pengenalan sekiranya pembayaran di buat ke atas waris.*
- ☐ Proof of Net Asset Value (NAV), Balance of unit & unit price (Unit Trust) at his/her date of death. / *Bukti nilai asset bersih, baki unit dan nilai pada tarikh.*

Additional documents for Temporary Partial Disability Claim. / *Dokumen tambahan bagi tuntutan Kelatan Sementara Sebahagian.*

- ☐ Certified copy of light duty entitlement. / *Salinan kelayakan tugas-tugas ringan yang disahkan.*

Additional documents for Temporary Total Disability Claim. / *Dokumen tambahan bagi tuntutan Kelatan Sementara Sepenuhnya.*

- ☐ Certified copy of Medical Leave entitlement. / *Salinan kelayakan tugas-tugas ringan yang disahkan.*

Additional documents for Permanent Total Disability Claim. / *Dokumen tambahan bagi tuntutan Kelatan Kekal Sepenuhnya.*

- ☐ Certified copy of Medical examination board decision. / *Salinan kelayakan tugas-tugas ringan yang disahkan.*
- ☐ Certified copy of employment termination letter. / *Salinan surat penamatan perkhidmatan daripada majikan 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

Company Stamp / *Cop Syarikat*

Name / *Nama* :

Designation / *Jawatan* :

Date / *Tarikh* :

MEDICAL CERTIFICATION FOR DISABILITY

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

A. DIAGNOSIS	
1. Details of the exact diagnosis.	
2. Date of onset of symptoms and date of any recurrences.	
3. Date of the patient's first consultation with you for this condition.	
4. When was the patient informed of the diagnosis?	
5. To your knowledge please indicate the date from which the patient first become aware of the symptoms or conditions.	
6. Was the patient being referred to you from another clinic/hospital? If YES, please state the referring hospital?/clinic's address and telephone number.	
7. Has the patient suffered any previous episodes of this condition or any condition leading to it or relating to it? If YES, please provide the details.	Date Symptoms Diagnosis Treatment
8. Has the patient undergone any surgical procedures for this any condition leading to it or relating to it? If YES, please provide the details.	Date Symptoms Diagnosis Surgical Procedures
B. DISABILITIES	
1. What is the extent and severity of the patient's condition (eg. Is he/she able to commute by himself/herself? Is he/she able to concentrate on and complete the task by himself/herself, if so for how long?)	
2. Is the patient's condition improving, stable or deteriorating?	
3. Is the patient's condition permanent? If YES, please provide the estimated percentage of permanent disability against the 100% ability of its original function.	
4. What is the extent of the patient's expected recovery from this condition?	
5. When would the recovery be expected?	
6. To what extent would the patient's current condition affect his/her ability to perform his/her usual occupation?	
7. To what extent would the patient's ability to perform his/her usual occupation be affected after his/her expected recovery?	
8. To what extent would the patient's current condition affected his/her ability to perform any other occupation?	
9. To what extent would the patient's ability to perform any other occupation be affected after his/her exected recovery?	
10. Is the patient capable of practising current occupation on a full-time or part-time basis?	
11. Is the patient capable of practising other occupation? If yes, please describe type of work?	

C. ACTIVITIES OF DAILY LIVING: Please comment on whether the patient is able to perform the following activities of daily living

Washing, bathing Ability to wash or bath or shower on by other means to maintain personal cleanliness	☐ Yes	☐ No	Comments:
Dressing Ability to dress and undress and to put on and take off any medical appliance usually worn	☐ Yes	☐ No	Comments:
Toileting Ability to do all of the following: to get to and from the lavatory, to get on and off the lavatory, to maintain adequate level of personal hygiene	☐ Yes	☐ No	Comments:
Continence Ability to voluntarily control bowel and bladder function with or without the use of catheters, incontinence or other artificial aids.	☐ Yes	☐ No	Comments:
Feeding Ability to take any form of nourishment once it had been prepared and made available	☐ Yes	☐ No	Comments:
Mobility Ability to move in and out of a chair or bed	☐ Yes	☐ No	Comments:
Restriction in movement or lifestyle? If so, please give details	☐ Yes	☐ No	Comments:

D. ACTIVITIES OF DAILY LIVING: Please comment on whether the patient is able to perform the following activities of daily living

Temporary Partial Disablement I hereby certify that the patient has suffered temporary partial disablement due to the above condition and has been able to perform only light duties of his usual duties or jobs during the following periods:	From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
Temporary Total Disablement I hereby certify that the patient has suffered temporary total disablement due to the above condition and has not been able to perform only of his usual duties or jobs during the following periods:	From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
Permanent Partial Disablement I hereby certify that the patient has suffered permanent partial disablement due to the above condition and the details are as follows:	Percentage of disability: ☐☐ % Please state which limbs and details of its disablement
Permanent Total Disablement I hereby certify that the patient has suffered permanent total disablement due to the above condition and the are as follows:	Please state which limbs and details of its disablement
Please provide additional information, if any:	

E. DECLARATION BY THE ATTENDING PHYSICIAN

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

Name of patient: .....

NRIC/BC/Passport No.: ..... MRN: .....

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

Name: .....

Address: .....

.....

Official Seal:

Date: .....