



Takafulmalaysia

SYARIKAT TAKAFUL MALAYSIA BERHAD (131646-K)
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FOR OFFICE USE	
FOR MC0 PROCESSING	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 pengisyitharan palsu dibuat untuk menyokong tuntutan ini, maka tuntutan ini adalah dianggap batil 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
2. Correspondence Address / Alamat Surat-menjurat
3. Telephone **Telefon** 0 - Handphone **Telefon Bimbis** 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 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 ketulenanya 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 sahlih 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 / Cap 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.	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO							

B. MEDICAL HISTORY

1. Has the patient ever been treated previously for this condition? If YES, please state exact date. (DD/MM/YYYY)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>
2. Approximately, when did the patient first became aware of the condition? (DD/MM/YYYY)	<input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>		
3. In your professional opinion, when did the condition first develop. (DD/MM/YYYY)	<input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>		
4. Other medical practitioners previously consulted by the patient for this condition:			

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

<u>Name</u>	<u>Consultation Date (DD/MM/YYYY)</u>	<u>Address & contact number</u>
..... -
..... -
..... -
..... -

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

Hypertension	<input type="checkbox"/> YES	<input type="checkbox"/> NO	since :	Name & Address of Referring Physician (if any)
Cardiovascular Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	since :
Gastrointestinal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	since :
Malignancy of Any Kind	<input type="checkbox"/> YES	<input type="checkbox"/> NO	since :
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	since :
Others	<input type="checkbox"/> YES	<input type="checkbox"/> 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 : _____

Name : _____

Official Seal:

Professional Qualifications :

Data (SD/MMB) -

$$\boxed{} \quad \boxed{} \quad - \quad \boxed{} \quad \boxed{} \quad - \quad \boxed{} \quad \boxed{} \quad \boxed{}$$