TAKAFULmalaysia

HEAD OFFICE/
IBU PEJABAT:

Syarikat Takaful Malaysia Keluarga Berhad (131646-K)
27th 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

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

Important Notes / ***Nota Penting:***

1. The issuance and acceptance of this claim form is not an admission of liability by the Employer or Certificate Owner and if false statements or declarations be made in support of this claim shall be null and void. /***Pengeluaran dan penerimaan borang tuntutan ini bukan pengakuan liabiliti oleh Majikan atau Pemilik Sijil dan sekiranya kenyataan dan pengisytiharan palsu dibuat untuk menyokong tuntutan ini, maka tuntutan ini adalah dianggap batal dan tidak sah.***
2. All parts have to be completed by the Employer / Certificate Owner or Claimant (Part 1 - 4) . ***/ Semua bahagian hendaklah diisi oleh Majikan / Pemilik Sijil atau Penuntut (Bahagian 1 - 4).***
3. Medical Certification (Appendix 1 or 2) has to be completed by the Attending Physician and Patient or Guardian has to sign for the medical information authorization. / ***Laporan Perubatan (Appendix 1 atau 2) hendaklah dilengkapkan oleh Pegawai Perubatan yang merawat dan Pesakit atau Penjaga perlu menandatangani kebenaran maklumat perubatan.***

Please complete this form in full in CAPITAL LETTERS and tick [√] the boxes as appropriate. / ***Sila lengkapkan borang ini sepenuhnya dengan HURUF BESAR dan tandakan [√] pada kotak yang berkenaan.***

PART 1 : TYPE OF CLAIM / *BAHAGIAN 1 : JENIS TUNTUTAN*

☐ Death / Funeral Expenses
Kematian / Perbelanjaan Pengebumian

☐ Daily Hospital Allowance
Elaun Harian Hospital

☐ Temporary Total Disability (TTD)
Keilatan Sementara Sepenuhnya

☐ Permanent Partial Disability (PPD)
Keilatan Kekal Sebahagian

☐ Critical Illness / Terminal Illness
Penyakit Kritikal / Penyakit Membawa Maut

☐ Total Permanent Disability (TPD)
Keilatan Kekal Sepenuhnya

☐ Accidental Medical Reimbursement
Bayaran Balik Perbelanjaan Perubatan Akibat Kemalangan

PART 2 : DETAILS OF CLAIMANT / *BAHAGIAN 2 : BUTIR – BUTIR PIHAK YANG MENUNTUT*

Section A : Name of Member / Employee / Claimant /*Seksyen A : Nama Ahli / Kakitangan / Penuntut*

1	Name / ***Nama***	
2	MyKad / Passport / Army / Police No. / ***No. MyKad / Pasport / Tentera / Polis***	– –
3	Correspondence Address / ***Alamat Surat-menyurat***	Postcode / ***Poskod*** City / ***Bandar***
4	Telephone / ***Telefon***	– Mobile / ***Bimbit*** –
5	Email / ***Emel***	

Section B : Name of Deceased or Details of Person with Illness / Injury / Disability (Dependent)
Seksyen B : Nama Orang yang Meninggal Dunia atau Butir-butir Pihak yang Menghidap Penyakit / Kecederaan / Keilatan (Tanggungan)

6	Relationship with claimant / ***Hubungan dengan pihak yang menuntut***	☐ Spouse / ***Pasangan*** ☐ Child / ***Anak*** ☐ Others / ***Lain-lain (*** Please specify / ***Sila nyatakan)*** _____
7	Name / ***Nama***	
8	MyKad / Passport / Army / Police No. / ***No. MyKad / Pasport / Tentera / Polis***	– –
9	Correspondence Address / ***Alamat Surat-menyurat***	Postcode / ***Poskod*** City / ***Bandar***
10	Telephone / ***Telefon***	– Mobile / ***Bimbit*** –
11	Email / ***Emel***	

PART 3 : DETAILS OF CLAIM / *BAHAGIAN 3 :* BUTIR – BUTIR TUNTUTAN

Please complete this form in full in CAPITAL LETTERS and tick [√] the boxes as appropriate. / ***Sila lengkapkan borang ini sepenuhnya dengan HURUF BESAR dan tandakan [√] pada kotak yang berkenaan.***

DEATH / FUNERAL EXPENSES / *KEMATIAN / PERBELANJAAN PENGEBUMIAN*

☐ Accident / ***Kemalangan*** ☐ Illness / ***Penyakit*** ☐ Others / ***Lain-lain*** _____

Caused by Accident / *Disebabkan oleh Kemalangan*

Date of Death / ***Tarikh Kematian:***

_____

Date of Accident / ***Tarikh Kemalangan:***

_____

Post mortem report / ***Laporan bedah siasat?*** ☐ Yes / ***Ya*** ☐ No / ***Tidak***

Last working day / ***Hari terakhir bekerja:***

_____

Caused by Illness / *Disebabkan oleh Penyakit*

Date of Death / ***Tarikh Kematian:***

_____

Type of Illness / ***Jenis Penyakit:***

_____

Last working day / ***Hari terakhir bekerja:***

_____

* Supporting documents, please refer to Part 6 in Page 4 ***(Sila rujuk Bahagian 6 muka surat 4 bagi dokumen sokongan)***

DAILY HOSPITAL ALLOWANCE / ACCIDENTAL MEDICAL REIMBURSEMENT / *ELAUN HARIAN HOSPITAL / BAYARAN BALIK PERBELANJAAN PERUBATAN AKIBAT KEMALANGAN*

☐ Accident / ***Kemalangan*** ☐ Illness / ***Penyakit***

Caused by Accident / *Disebabkan oleh Kemalangan*

Place of Accident / ***Tempat Kemalangan:***

_____

Date & time of Admission / ***Tarikh & masa Kemasukan Hospital:***

_____ (: am/pm)

Date & time of Discharge / ***Tarikh & masa Keluar Hospital:***

_____ (: am/pm)

Caused by Illness / *Disebabkan oleh Penyakit*

Diagnosis / ***Diagnosis:***

_____

Date & time of Admission / ***Tarikh & masa Kemasukan Hospital:***

_____ (: am/pm)

Date & time of Discharge / ***Tarikh & masa Keluar Hospital:***

_____ (: am/pm)

* Supporting documents, please refer to Part 6 in Page 4 ***(Sila rujuk Bahagian 6 muka surat 4 bagi dokumen sokongan)***

CRITICAL ILLNESS / TERMINAL ILLNESS / *PENYAKIT KRITIKAL / PENYAKIT MEMBAWA MAUT*

Symptoms / ***Simptom***: _____

Date of Symptoms / ***Tarikh Simptom***: _____

Details of Exact Diagnosis / ***Maklumat Sebenar Diagnosis***: _____

Date of First Diagnosis / ***Tarikh Permulaan Diagnosis***: _____

* Supporting documents, please refer to Part 6 in Page 4 ***(Sila rujuk Bahagian 6 muka surat 4 bagi dokumen sokongan)***
* Medical report to be completed by attending physician (Appendix 1 - Part A and B) / ***Laporan perubatan hendaklah diisi oleh pegawai perubatan yang merawat (Appendix 1 - Bahagian A dan B)***

PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD) / *KEILATAN KEKAL SEBAHAGIAN / KEILATAN KEKAL SEPENUHNYA*

☐ Accident / ***Kemalangan*** ☐ Illness / ***Penyakit***

Date of Accident / ***Tarikh Kemalangan:*** _____

Symptoms / ***Simptom:*** _____

Date of Symptoms / ***Tarikh Simptom:*** _____

Diagnosis / ***Diagnosis:*** _____

Date of Diagnosis / ***Tarikh Diagnosis:*** _____

* Supporting documents, please refer to Part 6 in Page 4 ***(Sila rujuk Bahagian 6 muka surat 4 bagi dokumen sokongan)***
* Medical report to be completed by attending physician (Appendix 2 - Part A and B) / ***Laporan perubatan hendaklah diisi oleh pegawai perubatan yang merawat (Appendix 2 - Bahagian A dan B)***

PART 4 : DIRECT CREDIT INSTRUCTION / *BAHAGIAN 4 : ARAHAN PINDAHAN TERUS*

Payment to be made to the Employer / Certificate Owner / Claimant or Beneficiary (please tick (√) the appropriate box). / ***Pembayaran dibuat kepada Majikan / Pemilik Sijil / Pihak yang Menuntut atau Waris (sila tandakan (√) pada kotak yang berkenaan).***

☐ **EMPLOYER / CERTIFICATE OWNER / *MAJIKAN / PEMILIK SIJIL***

Employer Name / ***Nama Majikan:***

Employer Registration No. / ***Nombor Pendaftaran Majikan:***

Address / ***Alamat:***

Email / ***Emel:***

Bank Name / ***Nama Bank:***

Bank Address / ***Alamat Bank:***

Bank Account No / ***No Akaun Bank:***

Swift Code / ***Kod SWIFT:***

☐ **CLAIMANT OR BENEFICIARY / *PIHAK YANG MENUNTUT ATAU WARIS***

Beneficiary's Name / ***Nama Waris:***

Relationship with Person Covered / ***Hubungan dengan Orang yang Dilindungi:***

Address / ***Alamat:***

Email / ***Emel:***

Bank Name / ***Nama Bank:***

Bank Address / ***Alamat Bank:***

Bank Account No / ***No Akaun Bank:***

Swift Code / ***Kod SWIFT:***

Note / ***Nota*** : SWIFT CODE is required for the payment transaction of Foreign / International Bank / ***SWIFT CODE diperlukan sekiranya pembayaran dibuat ke atas Bank Luar Negara.***

Terms and Conditions / ***Terma dan Syarat*** :-

1. Please furnish a copy of the bank statement for verification purpose. / ***Sila kemukakan satu salinan penyata bank untuk tujuan pengesahan.***
2. If a copy of the bank statement is not provided, the Employer is deemed to have confirmed the account details provided in this form as valid and accurate.
   Jika salinan penyata bank tidak dikemukakan, Majikan 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 Employer / Claimant results in payment being credited to a third party bank account or if there is any loss incurred, the payment thereto is still deemed as a full payment and Syarikat Takaful Malaysia Keluarga Berhad (STMKB) 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 Majikan / Penuntut 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 Syarikat Takaful Malaysia Keluarga Berhad (STMKB) tidak akan bertanggungjawab atas segala liabiliti, dakwaan dan permintaan pada masa kini dan juga pada masa hadapan yang berkaitan dengan pembayaran tersebut.

PART 5 : DECLARATION BY EMPLOYER / CERTIFICATE OWNER AND/OR CLAIMANT / *BAHAGIAN 5 : PERAKUAN MAJIKAN /PEMILIK SIJIL DAN/ATAU PENUNTUT*

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.
Saya / kami dengan ini mengesahkan bahawa sepanjang pengetahuan saya/kami pernyataan di atas adalah benar dan tepat dan saya/kami tidak memalsukan atau memberikan pernyataan palsu untuk 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 responsibile 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 tersebut.

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

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

_____
Employer's / Certificate Owner's / Claimant's signature
Tandatangan Majikan / Pemilik Sijil / Penuntut
(Please affix official seal for Employer / Certificate Owner / Sila guna cop rasmi untuk Majikan / Pemilik Sijil)

PART6 : DOCUMENTS CHECKLIST / *BAHAGIAN 6 : SENARAI SEMAKAN DOKUMEN*

DEATH / FUNERAL EXPENSES / *KEMATIAN / PERBELANJAAN PENGEBUMIAN*

- ☐ Copy of claimant's NRIC / Passport
  Salinan Kad Pengenalan / Pasport penuntut
- ☐ Copy of beneficiary's NRIC / Passport
  Salinan Kad Pengenalan / Pasport waris
- ☐ Copy of death certificate
  Salinan sijil kematian
- ☐ Copy of burial permit
  Salinan permit kubur
- ☐ Copy of proof of relationship
  Salinan bukti hubungan
- ☐ Copy of police report (if any)
  Salinan laporan polis yang disahkan (jika ada)
- ☐ Copy of Post Mortem report (due to accident)
  Salinan laporan bedah siasat (akibat kemalangan)

DAILY HOSPITAL ALLOWANCE / *ELAUN HOSPITAL HARIAN*

- ☐ Copy of claimant's NRIC / Passport
  Salinan Kad Pengenalan / Pasport penuntut
- ☐ Discharge note or any statement / bills produced by the hospital
  Nota discaj atau penyata / bil yang dikeluarkan oleh hospital
- ☐ Copy of police report (if any)
  Salinan laporan polis (jika ada)
- ☐ Medical report from hospital (if bill amount more than RM500)
  Laporan perubatan dari hospital (sekiranya melebihi RM500)

ACCIDENTAL MEDICAL REIMBURSEMENT / *BAYARAN SEMULA PERUBATAN AKIBAT KEMALANGAN*

- ☐ Copy of claimant's NRIC / Passport
  Salinan Kad Pengenalan / Pasport penuntut
- ☐ Copy of police report
  Salinan laporan polis
- ☐ Medical report from hospital (if bill amount more than RM500)
  Laporan perubatan dari hospital (sekiranya melebihi RM500)
- ☐ Original bill and original receipt
  Bil dan resit asal

PERMANENT PARTIAL DISABILITY (PPD) / *KEILATAN KEKAL SEBAHAGIAN*

- ☐ Copy of claimant's NRIC / Passport
  Salinan Kad Pengenalan / Pasport penuntut
- ☐ Copy of police report (if any)
  Salinan laporan polis yang (jika ada)
- ☐ Medical board / SOCSO report
  Laporan lembaga perubatan / PERKESO
- ☐ Medical report from the attending specialist doctor
  Laporan perubatan daripada doktor pakar yang merawat
- ☐ All medical test results (MRI / CT Scan, Dialysis card, etc) and lab report
  Keputusan ujian perubatan (MRI / Imbasan CT, kad dialisis dan sebagainya) dan laporan makmal

TOTAL PERMANENT DISABILITY (TPD) / *KEILATAN KEKAL SEPENUHNYA*

- ☐ Copy of claimant's NRIC / Passport
  Salinan Kad Pengenalan / Pasport penuntut yang disahkan
- ☐ Copy of police report (if any)
  Salinan laporan polis yang disahkan (jika ada)
- ☐ Termination letter by employer
  Surat penamatan perkhidmatan dari majikan
- ☐ Medical board / SOCSO report
  Laporan lembaga perubatan / PERKESO
- ☐ Medical report from the attending specialist doctor
  Laporan perubatan daripada doktor pakar yang merawat
- ☐ Attendance record (optional unless requested by US)
  Rekod kehadiran (kecuali jika diminta oleh pihak KAMI)

CRITICAL ILLNESS / *PENYAKIT KRITIKAL*

- ☐ Copy of claimant's NRIC / Passport
  Salinan Kad Pengenalan / Pasport penuntut
- ☐ Medical report from the attending specialist doctor
  Laporan perubatan daripada doktor pakar yang merawat
- ☐ All medical test results (MRI / CT Scan, Dialysis card, etc) and lab report
  Keputusan ujian perubatan (MRI / Imbasan CT, kad dialisis dan sebagainya) dan laporan makmal

APPENDIX 1: CRITICAL ILLNESS / TERMINAL ILLNESS MEDICAL REPORT – "PART A"

MEDICAL CERTIFICATION FOR CRITICAL ILLNESS / TERMINAL ILLNESS	
THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN Please use separate sheet of paper if additional space is required	
A. GENERAL INFORMATION	
1. Are you the patient's regular medical attendant? If YES, for how long was the patient known to you?	
2. When were you first consulted for this condition?	
3. At that time, how long had the symptoms been present?	
4. When was the patient's condition first diagnosed?	
5. Approximately, when was the patient first become aware of the condition?	
6. When was the patient informed of the diagnosis?	
7. Was the patient referred to you from another clinic/hospital? If YES, please state the referring clinic/hospital's address and telephone number.	
8. Has the patient ever referred to Specialist for consultation or treatment? If YES, please provide the details.	
9. Has the patient suffered any previous episodes of this condition or any conditions leading to it or relating to it? If YES, please provide the details.	Date Symptoms Diagnosis Treatment
10. Has the patient undergone any surgical procedures for this condition or any condition leading to it or relating to it? If YES, please provide the details.	Date Symptoms Diagnosis Treatment

APPENDIX 1: CRITICAL ILLNESS / TERMINAL ILLNESS MEDICAL REPORT – "PART B"

MEDICAL CERTIFICATION FOR CRITICAL ILLNESS / TERMINAL ILLNESS

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

B. MEDICAL DETAILS

1. Details of the exact diagnosis.	

2. Please indicate whether the following documents are available. If YES, please provide a certified true copy of these documents to support the patient's application for critical illness claim.

a.	CT Scan report	☐ Yes	☐ No	n.	Kidney function test	☐ Yes	☐ No
b.	MRI report	☐ Yes	☐ No	o.	Hearing test report	☐ Yes	☐ No
c.	ECG report	☐ Yes	☐ No	p.	Gloscow report	☐ Yes	☐ No
d.	Radiological report	☐ Yes	☐ No	q.	Neuromotoe sensory report	☐ Yes	☐ No
e.	Histopathology report	☐ Yes	☐ No	r.	Burns report	☐ Yes	☐ No
f.	Haemotology report	☐ Yes	☐ No	s.	Laboratory investigation report	☐ Yes	☐ No
g.	Cardiax enzymes lab report	☐ Yes	☐ No	t.	Force ejection-fraction volume test	☐ Yes	☐ No
h.	Cardiac catheterisation report	☐ Yes	☐ No	u.	Blood tranfusion report	☐ Yes	☐ No
i.	Motor sensory test	☐ Yes	☐ No	v.	HIV test	☐ Yes	☐ No
j.	Neuro function test	☐ Yes	☐ No	w.	Other radiology report	☐ Yes	☐ No
k.	Motor Neuro report	☐ Yes	☐ No	x.	Other laboratory report	☐ Yes	☐ No
l.	Neurological report	☐ Yes	☐ No	y.	Operation report	☐ Yes	☐ No
m.	Liver function test	☐ Yes	☐ No	z.	Other investigation report	☐ Yes	☐ No

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 or 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 appliances usually worn.	☐ Yes ☐ No	Comments
Toileting Ability to do all of the following: to get to and from 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. 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: _____

Official Seal: _____ Date: _____

E. MEDICAL INFORMATION AUTHORISATION

I / we hereby authorise any hospital, 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 membenarkan 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)*** | D | D | – | M | M | – | Y | Y | Y | Y |

_____
Signature of person with critical illness / terminal illness or his / her guardian
Tandatangan pihak yang mengalami penyakit kritikal / penyakit membawa maut atau penjaga

APPENDIX 2: PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD) MEDICAL REPORT – "PART A"

MEDICAL CERTIFICATION FOR PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD)	
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 patient's first consultation with you for this condition.	
4. When was the patient informed of this 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 referred to you from another clinic/hospital? If YES, please state the referring clinic/hospital'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 Hospital Diagnosis Surgical Procedures
B. DISABILITIES	
1. What is the extent and severity of the patient's condition (e.g. 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 perfom 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?	

APPENDIX 2: PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD) MEDICAL REPORT – "PART B"

MEDICAL CERTIFICATION FOR PERMANENT PARTIAL DISABILITY (PPD) / TOTAL PERMANENT DISABILITY (TPD)

THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN
Please Use Separate Sheet Of Paper If Additional Space Is Required

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 or 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 appliances usually worn.	☐ Yes ☐ No	Comments
Toileting Ability to do all of the following: to get to and from 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

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: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y
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 any of his usual duties or jobs during the following periods:	From: D D / M M / Y Y Y Y To: D D / M M / Y Y Y Y
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
Total Permanent Disablement I hereby certify that the patient has suffered permanent partial disablement due to the above condition and the details 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: _____

Official Seal: _____ Date: _____

F. MEDICAL INFORMATION AUTHORISATION

I / we hereby authorise any hospital, 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 membenarkan 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 critical illness / terminal illness or his / her guardian
Tandatangan pihak yang mengalami penyakit kritikal / penyakit membawa maut atau penjaga