TAKAFULmalaysia

HEAD OFFICE/
IBU PEJABAT:

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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.

INDIVIDUAL MEDICAL INPATIENT CLAIM FORM / *BORANG TUNTUTAN PERUBATAN INDIVIDU PESAKIT DALAM*

Please tick (✓) boxes where appropriate */ Sila tandakan (✓) pada kotak yang berkenaan.*

☐ Admission */ Penghospitalan* ☐ Pre Hospitalization */ Sebelum penghospitalan* ☐ Post Hospitalization */ Selepas penghospitalan*

Part 1 (To be completed by Patient / Claimant) / *Bahagian 1 (Untuk diisi oleh Pesakit / Penuntut)*

1. Patient Name :
Nama Pesakit

2. NRIC (Old & New) :
No. K.P. (Lama & Baru)

3. a. Date of Birth : *Tarikh lahir* _____/_____/_____ **b. Age:** *Umur* _____ **Year** *Tahun* **c. Sex:** *Jantina* ☐ **Male** *Laki-laki* ☐ **Female** *Perempuan*

4. Policy No. / Member ID/ Certificate No/ Plan/ Company Name :
No. Polisi / No. Ahli / No. Sijil / Pelan / Nama Syarikat

5. Admission / Planned Admission Date:
Tarikh kemasukan hospital

6. Hospital Name :
Nama Hospital

7. Name of Attending Doctor/ Speciality :
Nama Doktor yang merawat/ Kepakaran :

Please tick (V) admission reason and answer accordingly
Sila tanda (V) sebab kemasukkan dan jawab soalan yang berkenaan

☐ **8. Accident** *Kemalangan*

a. Occurred on: *Berlaku pada* **Date** *Tarikh* _____/_____/_____ **Time** *Masa* _____ ☐ **am** *pagi* ☐ **pm** *petang*

☐ **9. Illness** *Penyakit*

a. Symptoms first appeared on: *Tarikh simptom tersebut bermula* **Date** *Tarikh* _____/_____/_____
b. Doctor(s) consulted for this condition:
Doktor-doktor yang dilawati bagi penyakit ini
c. Doctor's or Clinic Contact(Address & Telephone):
Alamat & Telefon Doktor atau Klinik untuk dihubungi

10. Declaration and authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I, the undersigned, understand the delivery of this form is in no way an admission of Company's 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.

I am fully aware of the limits as to my/Assured medical insurance under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same.

I, undersigned 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 accident/injury, to disclose to the Company or its representative such information. I agree that the Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including the Company's parent company, subsidiaries or any other associated companies within the Company's Group, reinsurers, medical examiners, claims investigators and industry associations/federations etc.) and my employer in relation to this claim. This authorization shall bind my/the Assured's successors and assigns and remain valid notwithstanding my/Insured'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 insured's condition, the Company shall absolutely forfeit my/the Insured's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

Pengisytiharan dan pemberikuasa

Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti Syarikat ini ke atas tuntutan saya/Asured dan saya bersetuju bahawa bayaran kepada hospital oleh Syarikat atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti Syarikat dan Syarikat berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had insurans perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh insurans berkenaan.

Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/Assured, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada Syarikat atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan Syarikat atau wakilnya untuk mengguna dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkait dalam Syarikat, reinsurer, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) dan majikan saya berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/Asured dan kekal sah meskipun setelah kematian saya/Assured setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, Syarikat berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Signature of Patient / *Tandatangan Pesakit*	**Signature of Assured/ claimant /** *Tandatangan Pemilik Polisi /Penuntut*	**Signature of Witness /** *Tandatangan Saksi*
Full Name / *Nama Penuh* **:**	**Full Name /** *Nama Penuh* **:**	**Full Name /** *Nama Penuh* **:**
IC No. / *No. KP* **:**	**IC No. /** *No. KP* **:**	**IC No. /** *No. KP* **:**
Date / *Tarikh* **:**	**Date /** *Tarikh* **:**	**Date /** *Tarikh* **:**
Contact No. / *No. Telefon* **:**	**Contact No. /** *No. Telefon* **:**	**Contact No. /** *No. untuk dihubungi :*
	Relationship to Patient : / *Hubungan dengan Pesakit*	

Part 2 ADMISSION SECTION (To be completed upon admission by Doctor)

1. a. Patient name: b. NRIC: c. Age: d. Sex: ☐ Male ☐ Female

2. Policy No. / Member ID / Certificate No. / Plan / Company No. :

3. Admission No. / MRN and Hospital Name/ Hospital Contact and Fax No :

4. Admission Date and Time:

5. Expected days of stay / Discharge Date:

6. a. Symptoms / Conditions requiring admission:

b. How long is patient aware of the condition:

b. Patient's BP/ Temp/ Pulse:

d. Date symptoms first appeared: _____/_____/_____

e. Date first consulted: _____/_____/_____

7. 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 below:

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 / Hospitalization	Doctor / Hospital/ Clinic

d. Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
If no, please provide reasons of admission :

8. a. ☐ Admitting Diagnosis:

or

b. ☐ Provisional Diagnosis:

c. Diagnosis confirmed on _____/_____/_____
Advised patient on _____/_____/_____

d. Cause and pathology underlying the present diagnosis:

e. Any possibility of relapse? ☐ Yes ☐ No

9. Estimated Total Costs : RM

10. Admission requires: a. ☐ Hospitalisation b. ☐ Day Care c. ☐ On Pt's Request

11. Is the illness / condition related to: (please tick (√) if YES).

		Please provide details:			Please provide details:
a) ☐	Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage Or any complications arising therefrom.	_____	e) ☐	Cosmetic reason / Dental care / refractive errors correction	_____
b) ☐	Congenital / Hereditary diseases	_____	f) ☐	AIDS / STD / VD/ HIV	_____
c) ☐	Influence of Drugs / Alcohol	_____	g) ☐	Self-inflicted injuries / Violation of laws / Strike / Riots	_____
d) ☐	Nervous / Mental / Emotional / Sleeping Disorder	_____	h) ☐	None of the above	_____

12. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):

13. Any other medical/surgical conditions present? ☐ No ☐ Yes, details below:

a. _____ since _____/_____/_____

b. _____ since _____/_____/_____

14. Was the patient pregnant at the time of hospitalization? (For Female Only)

☐ No ☐ Yes, _____ months

15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:

b. Please indicate date/time of accident: (dd/mm/yy) _____/_____/_____ (hrs) _____ ☐ am ☐ pm

16. 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.

Date	Name & Signature of Attending Doctor	DR's Contact no. and Email addresss:	Doctor / Hospital Stamp

DISCHARGE SECTION (To Be Completed Upon Discharge by Doctor)

17. Undertaking Letter Ref No.:(If available)

18. Date of Discharge

19. a. Final Diagnosis:

ICD code:

b. Cause and pathology of the diagnosis:

20. Treatment given / Investigation done: (Please supply copy of all investigation results).

21. a.Surgical procedures performed:

MMA code / PHFSR code:

b. Date of surgery / procedure:

22. a. Recovery complication that arose (if any):

b. In the case of DEATH, please advise Date/ Time and Cause of death :

23. 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.

Date	Name & Signature of Attending Doctor	Doctor / Hospital Stamp

Important Notice / *Notis Penting*

Please submit the following documents to support your claim: / *Sila sertakan dokumen-dokumen di bawah untuk menyokong tuntutan anda:*

- ❑ Individual Medical Inpatient Claim Form /
  Borang Tuntutan Perubatan Individu Pesakit Dalam
- ❑ Original medical bills and itemized billing
  Bill-bil asal perbelanjaan perubatan dan bil terperinci
- ❑ Original medical receipts
  Resit-resit asal perbelanjaan perubatan
- ❑ **Additional document for illness/injury due to accident**
  Dokumen tambahan bagi penyakit/kecederaan akibat kemalangan
- ❑ Certificate 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.*

Important Note :-

Approved Claims payments will be automatically credited into the bank account as provided by the Participant in the Proposal and Declaration Form (or latest Endorsement Form). If Participant has never previously provided banking information to Syarikat Takaful Malaysia Keluarga Berhad, please provide the relevant details below:

Nota Penting :-

Pembayaran tuntutan yang diluluskan akan dikreditkan secara automatik ke dalam akaun bank seperti yang dikemukakan oleh Peserta di dalam Borang Cadangan dan Akuan (atau Borang Endorsemen terkini). Jika Peserta sebelum ini tidak pernah mengemukakan maklumat perbankan kepada Syarikat Takaful Malaysia Keluarga Berhad, sila kemukakan butiran yang berkaitan di bawah.

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*	
Occupation */ Perkerjaan*	
Employer */ Majikan*	
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 yang diselenggara Malaysia sahaja. Bagi pelanggan luar negara, kami akan menilai setiap kes sebelum membenarkan kemudahan Kredit Terus ini.
2. Direct 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 dan No. Kad Pengenalan/ No. Pasport yang digunakan bagi membuka akaun bank untuk tujuan pengesahan.

* 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.