ACCIDENT CLAIM FORM (GROUP CLAIM)

SECTION A

Every question must be fully answered and the Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Contract No: ……..

Broker/ Account Manager's Name : .....

Broker/ Account Manager's Contact No. : .....

Instruction – Supporting documents required

- ☐ Accident Claim Form
- ☐ Accident Statement of Medical Examiner
- ☐ Certified copy of Hospital Discharge Summary (if hospitalised)
- ☐ Original or certified copy of Medical Certificate (MC) and Light Duly Certificate duly endorsed by doctor due to accident
- ☐ Certified copy of Participant and/or Claimant's IC
- ☐ X-ray report / Radiologist report for cases with fracture bones
- ☐ Photograph of dismemberment / amputation (if any)
- ☐ Police report (if any)

1. Participant's Details

Name of Participant : ……..……..

NRIC No. : …….. BC / Old IC No. : …… Age : ……..

Sex : ☐ Male ☐ Female Date of Birth : ……..…… Marital Status : ……

Correspondence Address : ……..……

……..……

Mobile Phone No. : ……..…..…..... Office Phone No. : ..... House Phone No. : ……..…..…..

Fax No. : …….. E-mail Address : ……..…..

If working, please state :

i) Present Occupation : ……

ii) Exact nature of occupation and duties : ……

iii) Involved in manual work ? ☐ Yes ☐ No

iv) Name & address of employer : ……

v) Office Telephone No. : ..... vi) Date join company : .....

2. Claimant's Details (If other than Participant)

Name of Claimant : ……..……..

NRIC No.: ……..... Old IC No. : ……

Correspondence Address: ……..……..

……..……..

Mobile Phone No. : ……..…..…..... Office Phone No. : ..... House Phone No. : ……..…..…..

Fax No. : …….. E-mail Address: ……..……..

3. Particulars of Accident

i. Date of accident happen : .....(dd/mm/yyyy) Time of accident :.....(am/pm)

ii. Place of accident :.....

iii. How did the accident happen?.....

iv. Details of injuries sustained :.....

v. Date absent from work : .....(dd/mm/yyyy) Date return to work :.....(dd/mm/yyyy)

vi. Date of **first** consultation : .....(dd/mm/yyyy)

vii. Name of **first** clinic / hospital consulted for this injury : ……

viii. Address of the clinic / hospital : ……

ix. Contact no. of the clinic / hospital : ……..

4. Please give details of doctors that have been consulted in connection with this injury:

Date of Consultation	Name of Doctor (s)	Name of clinic / Hospital & Address	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)

Name, address and contact no. of the Participant's regular doctor other than above :

……..……

5. Are there other policies in force on the Participant's life taken with other companies? ☐ Yes ☐ No
If yes, please furnish the following details :

Name of Company	Policy No.	Type of Coverage	Amount of Compensation (RM)	Date which the policies were effected
…….	……	…….	……	……..

6. Please state bank account details in order for us to credit the payment directly into Claimant's bank account.

Bank : ……Bank Branch: ……..Account No: ……..

Bank Account Holder Name: ……...

Company Registration No……(Eg:266243D)

The Payment which has been made based on the account details provided by you will be deemed as full payment and we shall be discharged from any existing and future claim and demand in relation to it.

DECLARATION

I hereby declare that the foregoing answers and statements on the Participant are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish to Etiqa Takaful Berhad or its representative any information that maybe required concerning my health conditions, for settlement of this claim. I agree that Etiqa Takaful Berhad or its representative may use or disclose any of the information collected or held to third parties such as reinsurers, medical examiner or medical consultant, claims investigator and etc. within or outside Malaysia for the purpose of processing the claim. I agree that a photocopy of this authorization shall be considered as effective and valid as original.

_____ __	_____	_____
Signature / Thumb print of Life Assured	Signature of Witness	Authorized Signature of Contract Holder & Company's Stamp
Name:_____	Name :_____	Full Name : _____
Date : _____	NRIC No : _____	Designation: -_____
	Date : _____	Date :_____
		Contact No._____

LETTER OF AUTHORISATION / CONSENT

To Obtain Further Medical information

TO WHOM IT MAY CONCERN

Name of Participant …….

NRIC No. ……(New) ……..(Old)

Contract No. ……..

I, ……..., NRIC No. …… hereby authorize and give my consent to any medical practitioner, physician, surgeon, nurse, medical staff, clinic, hospital, medical centre, insurance company or organization or individual concerned ("the information provider") that may have any record or knowledge of health or medical history of the above stated ("Participant") and to provide such information to Etiqa Takaful Berhad and its authorized service provider and/or its employees in order to process my takaful claim.

I, agree, consent and allow Etiqa Takaful Berhad (hereinafter called "Etiqa Takaful") to process my personal data (including sensitive personal data) ('Personal Data') with the intention of processing this Claim Form, in compliance with the provisions of the Personal Data Protection Act 2010.

I expressly waived all provisions of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on myself in a professional and/or client capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorization/consent is irrevocable and a copy of it will have the same effect and validity as the original.

……
Signature of Participant / Claimant (If Participant is a minor)

Name: ……..

Relationship with Participant : ……..

Date: ……

Etiqa Takaful Berhad (266243D)
Level 19, Tower C, Dataran Maybank, No 1, Jalan Maarof, 59000 Kuala Lumpur
T +603 2297 3888 F +603 2297 3800 E info@etiqa.com.my www.etiqa.com.my