



Insurance & Takaful

Personal Accident Claim Form

Important Notice:

- The participant/policy holder/claimant must give complete and accurate information.
- For your easy accessibility, this claim form is made available at our website www.etiqa.com.my

Details of Participant / Policy Holder / Claimant

Name/ Name of Company				
NRIC / Army / Police / Passport No./ Company Registration No.				
Contact Details (if changed)	Phone No	Mobile	House	Office
	Email			
Address (if changed)				
Postcode	Town	State	Country	
Bank Name		Account No.		
Occupation (if changed)				
Purpose of Notice	<input type="checkbox"/> For Notification only	<input type="checkbox"/> Claim		

Details of Injured Person

Name	
Relationship with Policy Holder	

Details of the Accident

Date of Accident	_____ (dd/mm/yyyy)	Time (am/pm)
Location of Accident		
Description of Accident		
Injuries Sustained		
Medical Leave Given?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please provide slip

Declaration

I/We declare that the above statements and particulars are correct and complete in every aspect and I/We have not concealed, misrepresented or misstated any material fact in relation to this claim.

I/We agree that if such statements and particulars are written by any other person, such person shall be deemed to have been my/our Agent for the purpose of filing in this form and his statement shall be binding upon me/us.

I/We hereby agree to give my/our fullest cooperation to Etiqa Insurance Berhad/Etiqa Takaful Berhad or its authorized representative in relation to this claim.

Signature of Participant / Policy Holder / Claimant

(dd/mm/yyyy)

To be Completed by Attending Doctor
Details of the Patient / Injuries

Name of Patient		
Description of Injuries Sustained		
Information on Injuries	<input type="checkbox"/> Pre-existing	<input type="checkbox"/> First Time Detected
Injuries Sustained Consistent with the Accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Injuries Contributed by Degenerative/Disease/Any Contributory Causes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Please Provide Details		
Ambulance Services Used	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How was the Patient Treated	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Inpatient / Warded
Patient was Influenced by Alcohol / Drug at the Time of Accident	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Details of Treatment

Name of Hospital / Clinic			
Hospital / Clinic Address			
Postcode	Town	State	Country
Contact No			
Name of Doctor			
Date of First Outpatient Treatment	_____ (dd/mm/yyyy)		
Hospital Confinement Period	_____ (dd/mm/yyyy)	to	_____ (dd/mm/yyyy)
ICU / HDU Confinement Period	_____ (dd/mm/yyyy)	to	_____ (dd/mm/yyyy)
Surgery Performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Type of Surgery	<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> General Anesthetic	
Nursing Period	_____ (dd/mm/yyyy)	to	_____ (dd/mm/yyyy)

Details On Disabilities

Comment On Permanent Disabilities	<input type="checkbox"/> No Disability	<input type="checkbox"/> Disability In Possible Future
<input type="checkbox"/> Disability Is Apparent (If yes, please provide details) _____		

Details On Death

Date of Death	_____ (dd/mm/yyyy)	
Cause of Death		
Was Due To	<input type="checkbox"/> Accident Injuries	<input type="checkbox"/> Illness / Disease / Any Contributory Cause
If Illness / Disease / Any Contributory Cause, Please Elaborate		

Declaration

I certify that the above information is correct to the best of my knowledge		
Doctor's Signature and Qualification		
	Date	_____ (dd/mm/yyyy)

