eTiQa

HOSPITAL CONFINEMENT CLAIM FORM
Borang Tuntutan Kemasukan Hospital

Instruction

Please keep this claim form together with our Policy in a safe place. It should be completed and returned to us ONLY when you are making a claim under your Policy following an illness or injury resulting in hospitalization.

Claim Procedures

In order for us to deal with your claim promptly,

1. Please complete Part A of this form
2. Please ensure Part B of this form be certified by attending doctor. (Should the doctor require a fee for doing this, it must be borne by you)
3. Return the duly completed claim form to us and enclose with supporting documents; such as Admission / Discharge Note, Hospital bills and Police report (if motor vehicle accident)

Notification of hospitalization should be given to us immediately, within 30 days form the date of

Remember : This hospitalization benefit is a fixed daily amount and is not based on medical expenses incurred.

Send complete Claim form to Etiqa Insurance Bhd at the address shown on last page of this form.

Arahan

Sila simpan borang tuntutan ini bersama-sama Polisi anda di tempat yang selamat. Borang ini HANYA perlu dilengkapkan ketika membuat tuntutan ke atas Polisi anda jika anda dimasukkan ke hospital kerana jatuh sakit atau ditimpa kemalangan.

Cara-cara membuat Tuntutan

Untuk memproses tuntutan anda dengan segera,

1. *Sila penuhkan Bahagian A borang ini.*
2. *Sila dapatkan doktor yang merawat untuk melengkapkan Bahagian B borang ini. (Doktor mungkin mengenakan bayaran untuk tujuan ini dan anda haruslah membiayainya sendiri.*
3. *Serahkan dokumen yang telah dilengkapkan kepada kami beserta dokumen-dokumen sokongan seperti Ringkasan Discaj, Bil-bil hospital, dan laporan polis (sekiranya kemalangan jalan raya)*

Sila maklumkan kepada pihak kami sekiranya dimasukkan ke hospital dalam tempoh 30 hari dari tarikh kemasukan ke hospital.

Perhatian : Bayaran pampasan hospital ini adalah berdasarkan jangka masa anda berada di dalam hospital dan bukan di atas bayaran perubatan/rawatan yang anda terima semasa berada disana.

PART / *BAHAGIAN* A	To be completed by the Accountholder *Hendaklah diisi oleh Pemegang Akaun*

Policy no. / Nombor Polisi : ____________________

Claim no. / No. tuntutan : ____________________

1 Accountholder Information / *Maklumat Pemegang Akaun*

Policyholder full name/ *Nama penuh pemegang polisi :*

Address/ *Alamat :*

Telephone No./No Telefon

I/C No./No. K/P :

Occupation/Pekerjaan

Are you claiming under any other insurance? If yes, please provide details/ *Adakah anda membuat tuntutan insuran lain? Jika ya, sila nyatakan.*

2 Hospitalised Person Information / *Maklumat Orang yang dimasukkan ke Hospital*

Full name & address of the person admitted/ *Nama penuh dan alamat orang yang dimasukkan ke hospital*

I/C No./No. K/P :

Date of birth / *Tarikh lahir*

Age/ *Umur*

Relationship to Accountholder/ *Hubungan dengan Pemegang Akaun*

3 Claim Information / Keterangan Tuntutan

1. a) If due to sickness, please give full details of the disease/ *Jika penyakit, sila jelaskan penyakit yang dialami*

   ____

   ____

   b) Date Symptom first appeared/ *Tarikh pertama kali tanda-tanda penyakit ini diketahui :* ____________

   c) Have you ever suffered from this before? If yes, when? / *Pernahkah anda mengalami penyakit ini? Jika ya, bila?*

   (i) Few years ago, but has recovered / *Beberapa tahun yang lepas tetapi telah pulih* ☐

   (ii) Few month ago / *Beberapa bulan yang lepas* ☐

   (iii) Few weeks ago / *Beberapa minggu yang lepas* ☐

2. If accident / *Sekiranya kemalangan :-*

   (a) Place / *Tempat :* ______________________________

   (b) Date / *Tarikh :* ____________ Time / *Masa :* ____________

   (c) Details of accident / *Maklumat kemalangan :* ______________________________

   ____

   (d) Details of injuries sustained / *Nyatakan kecederaan yang dialami :* ____________

   ____

3. When di you/the person first consult a Medical Practitioner in connection with the conditio? / *Bilakah anda/penama ini mula mendapatkan rawatan daripada Pengamal Perubatan berhubung keadaan ini?*

   Date / *Tarikh :* ______________________________

   Name of doctor / *Nama doktor :* ______________________________

   Hospital/Clinic / *Hospital/Klinik :* ______________________________

4. At the time of admission to hospital, was the person / *Semasa dimasukkan ke hospital, adakah penama :*

   (a) pregnant? / *mengandung?* ☐ Yes/ *Ya* ☐ No/ *Tidak*

   (b) taking drug or medication? / *mengambil dadah atau ubat-ubatan?* ☐ Yes/ *Ya* ☐ No/ *Tidak*
   If yes, for how long? / *Jika ya, sudah berapa lama?*

   ____

   (c) undergoing treatment for any mental disease or disorder / *sedang menjalani rawatan kerana sakit mental atau tidak waras* ☐ Yes/ *Ya* ☐ No/ *Tidak*

   (d) undergoing treatment for HIV / *sedang menjalani rawatan penyakit HIV* ☐ Yes/ *Ya* ☐ No/ *Tidak*

5. Name of Doctor & Hospital where you were hospitalized / *Nama doktor dan hospital anda dimasukkan :*

   ____

   ____

6. Period of hospitalisation for which benefit is claimed / *Tempoh penghospitalan dimana pampasan ini dibuat :*

   (i) Admitted to ICU (Intensive Care Unit) / *Masuk ke wad ICU :*

   Date admitted / *Tarikh dimasukkan :* ____________ Time / *Masa :* ____________

   Date discharged / *Tarikh keluar :* ____________ Time / *Masa :* ____________

   (ii) Admitted to normal ward / *Masuk ke wad biasa :*

   Date admitted / *Tarikh dimasukkan :* ____________ Time / *Masa :* ____________

   Date discharged / *Tarikh keluar :* ____________ Time / *Masa :* ____________

DECLARATION

I hereby declare that the above information and statements are true and made without reservation and I, the Policyholder / Accountholder claim to be paid the benefits due to the Policy. I hereby authorize any hospital or clinic doctor or other person who has attended or examined me to disclose to Mayban General Assurance Berhad when requested to do so, any all information with respect to any illness and injury, medical history, consultation, prescrition or treatment. A copy of this authorization shall be considered as effective and valid as the original.

Saya dengan ini mengaku bahawa kenyataan diatas adalah benar dari setiap aspek dan dibuat tanpa was-was dan saya, Pemegang Polisi / Pemegang Akaun menuntut dibayar pampasan dibawah Polisi ini. Saya dengan ini membenarkan mana-mana doktor hospital atau klinik atau sesiapa sahaja yang telah merawat atau memeriksa saya, memberitahu Mayban General Assurance Berhad apabila dikehendaki berbuat demikian mengenai sebarang atau semua maklumat yang berkaitan dengan sebarang penyakit atau kecederaan. Salinan surat pemberikuasaan ini hendaklah dianggap berkuatkuasa dan sah seperti surat asal.

Signature of Accountholder/Tandatangan Pemegang Akaun : ____________________ Date/ *Tarikh :* __________

Signature of Insured Person/Tandatangan Orang Yang Diinsurankan : ____________________ Date/ *Tarikh :* __________

PART / *BAHAGIAN* B	**MEDICAL CERTIFICATE** To be completed by the doctor in attendance (any fee for this certificate is payable by the patient ***SIJIL PERUBATAN*** *Hendaklah dilengkapkan oleh doktor yang merawat anda (jika ada pembayaran untuk Sijil ini, hendaklah dijelaskan oleh pesakit)*

1. Name of patient : ____________________ I/C No : ____________________
2. Type : ☐ Illness ☐ Injury
3. Diagnosis : ____________________

   ____
4. (a) If injury, when did accident occur? ____________________

   (b) Do you think that the patient was intoxicated by alcohol or drug at the time of accident?

   ____

   (c) If sickness, when did symptom first occur? (months ago / years ago) ____________________

   ____
5. (a) When was the patient first referred to you in connection with the above condition?

   Date : ____________________

   (b) What was the patient presenting complain?

   ____

   ____

   (c) Has the patient ever had this illness or any similar condition before, but has recovered? (weeks ago/month ago/ years ago)

   ☐ Yes ☐ No

   If yes, please provide details : ____________________

   ____

(d) Has the patient ever sought treatment for this condition elsewhere other than you?

☐ Yes ☐ No

If yes, name of doctor : ______________________

Hospital/Clinic address : ______________________

____

6. Details of this admission.

(a) Name of hospital : ______________________

(b) Please give details of treatment(s) during this admission.

____

____

____

(c) Please confirm the periods of such hospitalization :

(i) Admitted to ICU (Intensive Care Unit)

Date admitted : ______________ Time : ______________

Date discharged : ______________ Time : ______________

(ii) Admitted to normal ward

Date admitted : ______________ Time : ______________

Date discharged : ______________ Time : ______________

(d) If hospitalization is continously for 5 days or more, please indicate whether this is upon the request of the Patient?

____

____

7. Are you the patient's usual doctor? ☐ Yes ☐ No

8. Details of Death

(a) Date of Death : ______________________

(b) Please provide details on the cause of the Death :

____

____

____

Declaration

I further certify that the above information is correct to the best of my knowledge and belief.

Doctor's signature : ______________ Date : ______________

Name of doctor : ______________ Qualification (Official Stamp) :

Claims Management, Non-Life Operations

Mayban General Assurance Berhad (4157-A)

Level 12, Tower B, Dataran Maybank, No 1, Jalan Maarof, 59000 Kuala Lumpur, Malaysia

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