MEDICAL EXPENSES CLAIM FORM

The issue of this form is not an admission of liability on the part of the Company. Please answer all questions fully and return this form to us without delay.

POLICY/ CERTIFICATE	No : ______
EMPLOYEE	Full Name : ______ Benefit Grade : ______ Occupation (Describe fully) : ______ Home Address : ______ ______ Relationship of patient to employee : ☐ Myself ☐ Spouse ☐ Children
PATIENT	Nature of illness or injury : ______ ______ Date and Time of Accident or commencement of illness : ______ Date ceased work : ______ Resume work : ______ MC date unfit : ______ Date first attended by doctor : ______ Name and address of doctor : ______ ______ Has insured person previously suffered from the same injury/illness ? ______ If yes, give details : ______ ______
PARTICULARS OF CLAIMS	Details of Treatment Received : ______ ______ ______ ______ Expenses : RM ______ Name of Medical Attendant : ______ Place of Treatment : ______
	Details of Hospitalisation : ______ ______ Expenses : RM ______ Admitted from ______ to ______ Name of Medical Attendant : ______ Address of Hospital : ______ ______
	Specialist Consultation (When applicable) : Name of Specialist : ______ Address : ______ ______ Referred to by : ______ Address : ______ ______ Nature of illness/treatment : ______ ______ ______ ______ Expenses : RM ______ **(Original bills of expenses must be forwarded to us together with this claim form)**

DECLARATIONS	By Employee/Retiree: I hereby declare the above statement and facts to be true and complete and that I have to the best of my knowledge and belief disclosed all material information connected with the above claim. Date : ________ Signature of Employee/Retiree : ________ Name : ________ NRIC No : ________ PF No : ________
	By Employer: We certify that to the best of our knowledge and belief the information provided above by the insured person are correct and the claim of RM is made in accordance to the terms and conditions of the said policy. Date : Signature of Employer ________ Name & Position : ________

N.B.

In accordance with the conditions of the policy/certificate, the company reserves the right to call for a Medical Report, to be furnished at the expense of the claimant.

Mayban General Assurance Berhad (4157-A)

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