Life Insurance

# GROUP CLAIMS CLAIMANT STATEMENT FORM

## GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

**Type of Claims**

*Note: Please tick (✓) the relevant claims type & refer to Claims Checklist for list of required supporting documents for submission*

☐ Hospitalisation Benefit (HB) ☐ Total Permanent Disability ☐ Terminal Illness ☐ Accidental Death

☐ Critical Illness ☐ Partial Permanent Disability ☐ AIR Weekly Indemnity ☐ Death ☐ Funeral

**Section A: Details of Life Assured / Deceased**

| | | | | |
|---|---|---|---|---|
| **Policy No** | | | | |
| **Name of Policyholder** | | | | |
| **Name of Insured Person** | | | | |
| **MyKad No. OR Other ID No.** | | | | |
| **Contact Details** | **Phone** | **Mobile:** | **House:** | **Office:** |
| | **Fax No.** | | **Email** | |
| **Current Corresponding Address** | **Postcod** | **Town:** | **State:** | |
| **Current Occupation & Job Nature** | | | | |

**Section B: Details of Claimant**

| | | | | |
|---|---|---|---|---|
| **Relationship with Insured Person** | ☐ **Own** | ☐ **Spouse** | ☐ **Child** | ☐ **Parent** |
| | ☐ **Employer** | ☐ **Contract Holder** | ☐ **Others** *(Please specify: )* | |
| **Name** | | | | |
| **MyKad No. OR Other ID No.** | | **Benefit Sum Assured** *(Applicable for Employers only)* | **RM** | |
| **Contact Details** | **Phone** | **Mobile:** | **House:** | **Office:** |
| | **Fax No.** | | **Email** | |
| **Current Corresponding Address** | **Postcode:** | **Town:** | **State:** | |
| **Bank Account Details** *(Current or Savings Account)* | **Bank Name** | | | |
| | **Bank Account Holder Name** | | | |
| | **Account Type** | ☐ **Current** | ☐ **Savings** | |
| | **Account Number** | ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ | | |

**Section C: Details of Claims**

**Claim Type : Death/ Accidental Death /Funeral Expanses Claim**

| | | | |
|---|---|---|---|
| **Date of Death** *(dd/mm/yyyy)* | | **Last Working Date (If employed)** | |
| **Any Post Mortem Done?** | ☐ **Yes** *(Please provide copy of the report)* | ☐ **No** | |

| **Claim Type : Hospitalisation /Critical Illness/ Terminal illness /AIR Weekly Indemnity Claim** | | | |
|---|---|---|---|
| **Date of Admission** *(dd/mm/yyyy)* | | **Date of Discharge** *(dd/mm/yyyy)* | |
| **Admitted Hospital** | | | |
| **Diagnosis** | | | |
| **First Date of Signs & Symptom for the Diagnosis** *(dd/mm/yyyy)* | | **Medical Certificate (MC) Dates** *(dd/mm/yyyy)* | |
| **Date of Accident** *(dd/mm/yyyy)* | | **Place of accident** | |

| **Claim Type : Total / Partial Permanent Disability Claim** | | | |
|---|---|---|---|
| **Date of Admission** *(dd/mm/yyyy)* | | **Date of Discharge** *(dd/mm/yyyy)* | |
| **Diagnosis** | | | |
| **First Date of Signs & Symptom for the Diagnosis** *(dd/mm/yyyy)* | | **Medical Certificate (MC) Dates** *(dd/mm/yyyy)* | |
| **Date of MC/ Prolonged Illness Leave** | **Start Date** *(dd/mm/yyyy):* | **End Date** *(dd/mm/yyyy):* | |
| **Current Salary Status** | ☐ **Full Salary** | ☐ **Half Salary** | ☐ **No Salary** |
| **Last Drawn Monthly Basic Salary** | **Paid Date** *(dd/mm/yyyy* | **Salary Amount RM** | |
| **Last Working Date** *(dd/mm/yyyy)* | | **Date of Resignation /Medically Boarded out / Early Retirement (if any)** | |

## DECLARATION

I do solemnly and sincerely declare that I am the nominee/administrator/beneficiary for the Insurance benefit of the deceased and further declare as follows:-

1. That the foregoing answers and statements on the Deceased are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
2. That any difference, if any, in respect of the details contained in the enclosed supporting document and the information presented to Etiqa Life Insurance Berhad (Etiqa) in this form refers to the same person. I understand and agree that Etiqa has the sole discretion to reject this application if the information given is false or insufficient.
3. That the original certificate whether or not enclosed therein (if any), due to loss or mutilated, belongs to the person covered.
4. And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish Etiqa or its representative any information that may be required concerning my health conditions, for settlement of this claim. I agree that Etiqa 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.
5. I, agree, consent and allow Etiqa (hereinafter called 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.
6. I, understand and agree that any Personal Data collected or held by Etiqa contained in this Claim Form may be held, used, processed and disclosed by Etiqa to individuals and/or organizations related to and associated with Etiqa or any selected third party (within or outside Malaysia, including medical institutions, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this Claim Form and providing subsequent service related to it and to communicate with me for such purposes.
7. I agree that a copy of documents submitted shall be as valid as the original. I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.

**Signature/ Thumbprint of claimant**
**Name:**
**Date**

**Official Stamp with designation of**
**(For Policyholder)**
**Date:**