Life Insurance

ACCIDENT CLAIM FORM

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.

Policy No: ……..

Agent's Name : .....

Agent's code & Agency : ..... Agent'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 Life Assured 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. Life Assured's Details

Name of Life Assured : ……

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 Life Assured)

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 Life Assured's regular doctor other than above :

……..…….....

5. Are there other policies in force on the Life Assured'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 your (the Claimant) bank account details in order for us to credit the payment directly into your bank account.

Bank : …… Account No: ……..……...

DECLARATION

I hereby declare that I/the Life Assured have/has sustained the injuries described above and warrant the truth or the foregoing particular in every respect and agree that I have made, or shall make any false or untrue statement, suppression or concealment, my / the Life Assured's right to compensation shall be absolutely forfeited.

Signature / Thumb print of Life Assured	Signature / Thumb print of Claimant	Signature of Witness
Name : _____	Name : _____	Name : _____
Date : _____	Date : _____	Date: _____
		NRIC No : _____
		Contact No : _____

LETTER OF AUTHORISATION / CONSENT

To Obtain Further Medical information

TO WHOM IT MAY CONCERN

Name of Life Assured ……

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 ("Life Assured") and to provide such information to Etiqa Life Insurance Berhad and its authorized service provider and/or its employees in order to process my insurance claim.

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 Life Assured / Claimant (If Life Assured is a minor)

Name: ……..

Relationship with Life Assured : ……..

Date: ……

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