



## Life Insurance

### CRITICAL ILLNESS CLAIM FORM

#### SECTION A

Every question must be fully answered. 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 & code: \_\_\_\_\_

Agent's Contact No: \_\_\_\_\_

#### Instruction – Supporting documents required

- ☐ Critical Illness claim form
- ☐ Certified copy of Life Assured and/or Claimant's IC
- ☐ Critical Illness - Statement of Medical Examiner (Stroke / Heart / End Stage Renal failure / Cancer / Others)
- ☐ Relevant diagnostic test results or report to support the diagnosis (Please refer page 4-5)
- ☐ Other supporting document (if applicable)

Name of Life Assured \_\_\_\_\_

New IC No \_\_\_\_\_ Old IC No. \_\_\_\_\_ Age \_\_\_\_\_

Correspondence Address \_\_\_\_\_

Mobile Phone No. \_\_\_\_\_ E-mail address \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Name of the Employer \_\_\_\_\_

Address of the Employer \_\_\_\_\_

Office Phone No. \_\_\_\_\_

Date of Employment \_\_\_\_\_ (dd/mm/yyyy)

1 Describe fully the symptoms for which you consulted a medical practitioner.

\_\_\_\_\_

2 Date symptoms **first** commenced \_\_\_\_\_ (dd/mm/yyyy)

3 Date you **first** consulted doctor for this condition \_\_\_\_\_ (dd/mm/yyyy)

4 Name & address of doctor you **first** consulted for this condition \_\_\_\_\_

\_\_\_\_\_

5 What was the diagnosis? \_\_\_\_\_

6 What treatment are you currently receiving? \_\_\_\_\_

7 Have you previously suffered from, or received treatment for a similar or related illness? ☐ Yes ☐ No

If yes, please give full details \_\_\_\_\_

8 State the name and address of your regular doctor \_\_\_\_\_

\_\_\_\_\_

9 Please give details of any other doctors you have consulted in connection with this or other conditions.

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

10 Are there other policies in force on your life taken with other companies? ☐ Yes ☐ No

If yes, please give details:

Name of Company(s)	Commencement date (dd/mm/yyyy)	Policy no	Type of coverage	Sum assured

11 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/We hereby declare that the foregoing answers and statements are complete and true to the best of my/our knowledge and belief, and that I/we have withheld no material facts from the Company.

\_\_\_\_\_  
Signature / Thumb print of Life Assured

Full Name: \_\_\_\_\_

Date: \_\_\_\_\_ (dd/mm/yyyy)

\_\_\_\_\_  
Signature / Thumb print of Claimant (if other than Life Assured)

Full Name: \_\_\_\_\_

Date: \_\_\_\_\_ (dd/mm/yyyy)

Contact No: \_\_\_\_\_

Designation & Official stamp is required for Company or Bank:

\_\_\_\_\_  
Signature of Witness

Full Name: \_\_\_\_\_

NRIC No: \_\_\_\_\_

Contact No: \_\_\_\_\_

Date: \_\_\_\_\_



**LETTER OF AUTHORISATION / CONSENT  
TO OBTAIN FURTHER INFORMATION (LIVING CLAIM)**

To Whom It May Concern,

Policy No: \_\_\_\_\_

Dear Sir / Madam,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of employment, financial, health or medical history of myself ("the Life Assured") and to provide such information to Etiqa Life Insurance Berhad or its authorised agents and/or employees.

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 rise, in supplying such information requested by the Company.

This authorisation / consent is irrevocable and a copy of it will have the same effect and validity as the original.

\_\_\_\_\_  
Signature / Thumb print of Life Assured

Name: \_\_\_\_\_  
NRIC: \_\_\_\_\_  
Old IC: \_\_\_\_\_  
Birth Cert No. (if minor): \_\_\_\_\_  
Tel No: \_\_\_\_\_  
Date: \_\_\_\_\_ (dd/mm/yyyy)

\_\_\_\_\_  
Signature is Policy holder (If Life Assured is a Minor)

Name: \_\_\_\_\_  
NRIC: \_\_\_\_\_  
Old IC: \_\_\_\_\_  
Tel No: \_\_\_\_\_  
Date: \_\_\_\_\_ (dd/mm/yyyy)

**Additional Requirements for Critical Illness Claim**

Critical Illness	Additional Required Medical Evidence
Stroke	<ol style="list-style-type: none"> <li>1. CT Scan / MRI of Brain report</li> <li>2. Doctor's Statement to be completed by Consultant Neurologist (for current condition at least 6 months after the stroke)</li> </ol>
Heart Attack	<ol style="list-style-type: none"> <li>1. Cardiac Enzymes Assay results (CK-MB)</li> <li>2. Electrocardiography report (ECG)</li> <li>3. Troponin T result, if any</li> <li>4. Doctor's Statement to be completed by Consultant Cardiologist</li> </ol>
End Stage Kidney Failure	<ol style="list-style-type: none"> <li>1. Dialysis appointment card / receipts</li> <li>2. Blood test results</li> <li>3. Doctor's Statement to be completed by Consultant Nephrologist</li> </ol>
Cancer	<ol style="list-style-type: none"> <li>1. Histopathology/biopsy report (where applicable)</li> <li>2. Bone Marrow Aspiration report (leukemia)</li> <li>3. CT Scan / MRI report (where applicable)</li> </ol>
Coronary Artery By-Pass Surgery	<ol style="list-style-type: none"> <li>1. Coronary Artery By-Pass Surgery Report</li> </ol>
End Stage Liver Failure	<ol style="list-style-type: none"> <li>1. Liver Function Test</li> <li>2. CT Scan of Liver</li> <li>3. All laboratory, pathology, hepatitis screening, ultrasound &amp; histology report</li> </ol>
Fulminant Viral Hepatitis	<ol style="list-style-type: none"> <li>1. CT Scan report of Liver</li> <li>2. Liver Function Test results</li> <li>3. Any other laboratory or pathology reports</li> </ol>
Coma	<ol style="list-style-type: none"> <li>1. Medical receipt for the usage of life support (Oxygen)</li> <li>2. Doctor's Statement to be completed by Consultant Neurologist</li> </ol>
Benign Brain Tumour	<ol style="list-style-type: none"> <li>1. CT Scan / MRI of Brain report</li> <li>2. Histopathology/biopsy report</li> </ol>
Paralysis / Paraplegia	<ol style="list-style-type: none"> <li>1. X-ray / CT Scan / MRI report, if available</li> <li>2. Doctor's Statement to be completed by Consultant Neurologist</li> </ol>
Blindness / Total Loss of Sight	<ol style="list-style-type: none"> <li>1. Visual Acuity report on both eyes to be done by an ophthalmologist</li> <li>2. Doctor's Statement to be completed by an Ophthalmologist</li> </ol>
Deafness / Total Loss of Hearing	<ol style="list-style-type: none"> <li>1. Audiometry test and Sound Threshold test results</li> </ol>
Major Burns	<ol style="list-style-type: none"> <li>1. Total Body Surface Assessment report</li> </ol>
End Stage Lung Disease	<ol style="list-style-type: none"> <li>1. Pulmonary Function test</li> <li>2. FEV 1 test</li> <li>3. Relevant medical reports</li> </ol>
Encephalitis	<ol style="list-style-type: none"> <li>1. CT Scan / MRI of Brain</li> <li>2. Doctor's Statement to be completed by Consultant Neurologist</li> </ol>
Major Organ / Bone Marrow Transplant	<ol style="list-style-type: none"> <li>1. Surgery report</li> </ol>
Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease	<ol style="list-style-type: none"> <li>1. Coronary Angiogram report</li> <li>2. Surgery report</li> </ol>
Loss of Speech	<ol style="list-style-type: none"> <li>1. Medical evidence from ENT specialist to confirm illness or injury to vocal cords</li> <li>2. Doctor's Statement to be completed by speech pathologist / therapist</li> </ol>
Brain Surgery	<ol style="list-style-type: none"> <li>1. Brain Surgery report</li> </ol>
Heart Valve Surgery	<ol style="list-style-type: none"> <li>1. Heart Valve Surgery report</li> </ol>

Critical Illness	Additional Required Medical Evidence
Terminal Illness	1. All relevant investigation result in support of the diagnosis
Bacterial Meningitis	1. CT Scan / MRI of Brain & Spine
Major Head Trauma	1. Detailed medical assessment from attending doctor 2. CT Scan / MRI of Brain 3. Police report, if any
Other Serious Coronary Artery Disease	1. Coronary Angiogram report
Chronic Aplastic Anaemia	1. Bone Marrow Aspiration 2. Blood test report
Motor Neuron Disease	1. All investigation reports
Parkinson's Disease	1. Detailed medical assessment including Activities of Daily Living from Consultant Neurologist
Muscular Dystrophy	1. Diagnostic test result 2. Doctor's Statement to be completed by Consultant Neurologist
Surgery to Aorta	1. Aorta Surgery report
Multiple Sclerosis	1. Ophthalmologist's report 2. CT Scan & MRI report of Brain & Spine 3. Doctor's Statement to be completed by Consultant Neurologist
Medullary Cystic Disease	1. Abdominal Ultrasound or Abdominal CT Scan 2. Renal biopsy report 3. Urine Specific Gravity Test 4. Blood test result 5. All clinical and laboratory investigation report
Severe Cardiomyopathy	1. Chest X-ray 2. Echocardiogram report
SLE with Lupus Nephritis	1. Urine test results 2. Blood test results 3. Kidney biopsy report
Primary Pulmonary Arterial Hypertension	1. All clinical and laboratory investigation including cardiac catheterization
Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders	1. Diagnostic test results