Life Insurance

PERMANENT PARTIAL DISMEMBERMENT

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

- ☐ Permanent Partial Dismemberment Claim Form
- ☐ Permanent Partial Dismemberment - Statement of Medical Examiner
- ☐ Certified copy of Life Assured and/or Claimant's IC
- ☐ Certified copy of police report, (if any)
- ☐ Close-up photograph as proof of loss / Full photo of claimant
- ☐ Certified copy of X-ray, MRI, CT Scan or other radiology reports
- ☐ Other supporting documents (if applicable)

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. Condition / Disability due to 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 illness / injury : ……

viii. Address of the clinic / hospital : ……

ix. Contact no. of the clinic / hospital : ……..

4. Condition / Disability due to Illness

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

……..

ii. Date symptoms **first** commenced.....(dd/mm/yyyy)

iii. Date you **first** consulted doctor for this condition .....(dd/mm/yyyy)

iv. Name & address of doctor you **first** consulted for this condition……

……..

v. What was the diagnosis? ……

vi. What treatment are you currently receiving? ……

5. Did you suffer amputation of limbs? ☐ Yes ☐ No

i. If yes, please stated which limb(s) is/are affected and exact location of amputation

……

6. Did you suffer loss of use of limbs and /or fingers, loss of eyes etc? ☐ Yes ☐ No

i. If yes, please give exact details……

7. Please give details of doctors that have been consulted in connection with this injury / illness:

Date of Consultation	Name of Doctor (s)	Name of clinic / Hospital & Address	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)

8. Name(s) of all medical practitioner(s) and clinic(s) / hospital(s) which (I/Life Assured*) have /has, sought or received medical treatment, advice, consultation and/or check-up within the **past three (3) years**.

Date of Consultation or Treatment etc.	Name of Doctor (s)	Name, Address and Telephone No of Clinic / Hospital

9. State the name and address of your regular doctor ……

10. 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
…….	……	…….	……	……..
…….	……	…….	……	……..

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 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

Name:_____

Date: _____

_____
Signature/Thumb print of Claimant (if different from Life Assured)

Name:_____

Date: _____

_____
Signature of Witness

Name:_____

NRIC No : _____

Date : _____

Life Insurance

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 organization, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of the 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 : _____

_____
Signature of Policy holder (If Life Assured is a minor)

Name : _____

NRIC : _____

Old IC : _____

Tel No. : _____

Date : _____

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