eTiQa Insurance

Hospital Confinement Claim Form

Important Notice:
- *The policyholder/ claimant must give complete and accurate information.*
- *For your easy accessibility, this claim form is made available at our website www.etiqa.com.my*

Information on Policyholder

Policy No.:			
Name of Policyholder:			
MyKad / Army / Police / Passport no./ Business registration no.:		Occupation:	
Contact details: Phone no.	Mobile:	House:	Office:
Contact details: Email:			

Address

Postcode | Town | State | Country

Bank name:		Account no.:	

Details of injured person

Name of patient:			
MyKad / Army / Police / Passport no.:			
Contact details: Phone no.	Mobile:	House:	Office:
Contact details: Email:			

Address

Postcode | Town | State | Country

Relationship of patient to policyholder:	

Claim information

If due to **sickness**, please provide full details of the disease:			
Date symptom first presented (dd/mm/yyyy):			
Have you ever suffered from this symptom before?	☐ Yes, when (dd/mm/yyyy):	☐ No	
If **accident**, please provide date of accident (dd/mm/yyyy):		Time (am/pm):	Location:
Details of the accident:			
Details of injuries sustained:			
When did you first consult a Medical Practitioner in connection with the condition?	Date (dd/mm/yyyy):	Name of doctor:	
	Name of hospital/ clinic:		
Do you have any other insurance policy / or made a claim from any other insurance besides Etiqa?	☐ Yes, please provide:	☐ No	
	Policy no:		
	Insurance co.:		

Declarations

I/We declare that the above statements and particulars are correct and complete in every aspect and I/We have not concealed, misrepresented or misstated any material fact in relation to this claim. I/We hereby authorize any hospital or clinic doctor or any other person who has attended or examined me to disclose to Etiqa General Insurance Berhad full particulars in respect to any illness and injury, medical history, consultation, prescription or treatment. A duplicate of this authorization shall be considered as effective and valid as the original.

Signature of patient
Date:

Signature of policyholder
Date:

Medical Certificate
To be completed by attending doctor
(any fees incurred for the completion of this medical certificate shall be borne by the patient)

Name of patient:				
Type:	☐	Illness	☐	Injury
Diagnosis:				
If **injury**, when did the accident occurred?				
Do you think that the patient was intoxicated by alcohol or drug at the time of accident?	☐	Yes	☐	No
If **sickness**, when did the symptom first occur?				
Is there any underlying cause/ pathology contributes to the above diagnosis?				
Does patient has any pre-existing illness/ congenital conditions?				
When did the patient first referred to you in connection with the above condition?				
What was the patient complain?	Yes, please provide name of doctor & hospital/ clinic:			
Has the patient ever had this illness or any similar condition before but has recovered?	☐	Yes, please provide details:	☐	No
Are you the patient usual medical attendant?	☐	Yes	☐	No
Has the patient ever sought treatment for this condition elsewhere other than you?	☐	Yes Name of doctor: Name of hospital / clinic:	☐	No
Have any investigations, tests or procedures been performed?	☐	Yes, please provide details:	☐	No
Has biopsy been done to confirm whether the cells/ tissues are cancerous? *(for cancer patient only)*				
Is the diagnosis being confirmed by histological evidence of malignancy?				
For heart attack, is the diagnosis made based on history of typical prolonged chest pain/ new ECG changes/ elevation of cardiac enzymes?				
For the diagnosis of stroke is there any documented evidence of permanent neurological deficit?				

Details of Admission

Please provide details of treatment(s) during this admission:			
Period of hospitalization	Normal ward	Date of admission (dd/mm/yyyy):	Time of admission (am/pm):
		Date of discharge (dd/mm/yyyy):	Time of discharge (am/pm)::
	Intensive care unit	Date of admission (dd/mm/yyyy):	Time of admission (am/pm)::
		Date of discharge (dd/mm/yyyy):	Time of discharge (am/pm)::
If hospitalization is continuously for 5 days or more, please indicate whether if this is upon request of the patient?			
At the time of admission to hospital, was the patient:	☐ Pregnant	☐ Taking drug or medication	
	☐ Undergoing treatment for any mental disease or disorder	☐ Undergoing treatment for HIV	

Details of Death

Date of death (dd/mm/yyyy):	
Please provide details on the cause of death:	

Declarations

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the company.

Signature of attending physician

Clinic / Hospital stamp

Date:

Name of attending physician & qualification

Tel no.: