

TOTAL & PERMANENT DISABILITY CLAIM FORM (GROUP CLAIM)

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.

Contract No : _____

Broker/Account Manager's name: _____ Broker/ Account Manager's Contact No. : _____

Instruction – Supporting documents required

- Total and Permanent Disability Claim form
- Total & Permanent Disability Statement of Medical Examiner
- Diagnostics / Radiology Reports
- Certified copy of Participant and/or Claimant's IC
- Letter of job termination / Medically Boarded Out from Participant's employer (if employed)
- Certified copy of clinic/ hospital consultation card
- Other supporting documents (if applicable) etc. SOSCO Pencen IIIat medical reports/letters

Name of Participant _____

New IC No _____ Old IC No. _____ Age _____

Correspondence Address _____

Mobile Phone No. _____ E-mail address _____

Phone No. _____ Fax No. _____

What is the highest level of education do you have? Primary Secondary Tertiary Post graduate

1 Please list the jobs held in the past 3 years

Dates (From -To) dd/mm/yyyy	Job Title & Employer's Address	Exact Duties of Work	Average monthly income (RM)

2 Name of the Employer prior to onset of disability _____

3 Address of Employer prior to onset of disability _____

Office Phone No. _____

4 Date of Employment _____ (dd/mm/yyyy) 5 Last date of Work _____ (dd/mm/yyyy)

6 Main duties prior to onset of disability _____

7 Work environment Factory Office Outdoors Type of industry _____

8 Are you in management or supervisory capacity? _____

9 Do you operate any machine or special equipments? Yes No

10 What is the qualification and/or skills needed for the job? _____

11 a. Any special skills required? _____

b. What is your normal working hours and days? _____

c. Are you required to work on shift, Sunday or on-call? _____

d. Any travelling (km/week) required by the job? _____

12 Condition/Disability due to Accident

- a. When did the accident happen? Date: _____ (dd/mm/yyyy) Time : _____ (am/pm)
- b. Where did the accident happen? _____
- c. What were you doing at the time of Accident? _____
- d. Describe in detail how the Accident happened ? _____

13 Condition/Disability due to Illness

- a. Describe fully the symptoms for which you consulted a medical practitioner. _____
- b. Date symptoms **first** commenced _____ (dd/mm/yyyy)
- c. Date you **first** consulted doctor for this condition _____ (dd/mm/yyyy)
- d. Name & address of doctor you **first** consulted for this condition _____
- e. What was the diagnosis? _____
- f. What treatment are you currently receiving? _____
- g. Have you previously suffered from, or received treatment for a similar or related illness? Yes No
If yes, please give full details _____
- h. State the name and address of your regular doctor _____

i. 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

14 When were you last able to work? _____ (dd/mm/yyyy)

15 What aspects of your disability prevent you from following your occupation/any occupation?

16 State the date when you are expected to resume your work and daily activities _____ (dd/mm/yyyy)

17 Do you intent to seek another employment? Yes No

If yes, the nature of work _____

If no, why? _____

18 Employment termination date _____ (dd/mm/yyyy)

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

i. If yes, please give details:

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

20 Please state bank account details in order for us to credit the payment directly into Claimant's bank account.

Bank : _____ Bank Branch : _____

Bank Account Holder Name : _____ Bank Account no.: _____

Company Registration no : _____ (Eg:266243D)

If the above bank account is a joint account, please provide below details:

Second account holder name : _____ Second account holder NRIC : _____

The Payment which has been made based on the account details provided by you will be deemed as full payment and we shall be discharged from any existing and future claim and demand in relation to it.

DECLARATION

I hereby declare that the foregoing answers and statements on the Participant are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.

And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish to Etiqa Life Insurance Berhad or its representative any information that maybe required concerning my health conditions, for settlement of this claim. I agree that Etiqa Life Insurance Berhad 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.

Signature / Thumb print of Participant

Name _____

Date _____ (dd/mm/yyyy)

Signature / Thumb print of Claimant (if other than Participant)

Date _____

Full name _____

Contact No _____

Designation & Official stamp is required for Company or Bank:

Signature of Witness

Date _____

Full Name _____

NRIC No _____

Contact No _____

Authorised Signature of Contract Holder & Company's Stamp

Full name _____

Designation: _____

Contact No _____

Date _____

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

To Whom It May Concern,

Contract 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 Participant") 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 Participant
Name _____
NRIC _____
Old IC _____
Birth Cert No. (if minor) _____
Tel No. _____
Date _____ (dd/mm/yyyy)

Signature of Contract holder (If Participant is a minor)
Name _____
NRIC _____
Old IC _____
Tel No _____
Date _____ (dd/mm/yyyy)