PERMANENT PARTIAL DISMEMBERMENT CLAIM FORM (GROUP CLAIM)

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.

Contract No: ……..

Broker/ Account Manager's Name : .....

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

Instruction – Supporting documents required

- ☐ Permanent Partial Dismemberment Claim Form
- ☐ Permanent Partial Dismemberment - Statement of Medical Examiner
- ☐ Certified copy of Participant 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. Participant's Details

Name of Participant : ……..

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. : ……..…..…..

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 Participant)

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/Participant*) 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 Participant'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 bank account details in order for us to credit the payment directly into Claimant's bank account.

Bank : ……Bank Branch: ……Account No: ……..……..

Bank Account Holder Name: ……...

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 Family Takaful Berhad or its representative any information that maybe required concerning my health conditions, for settlement of this claim. I agree that Etiqa Family Takaful 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: _____

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

Name:_____

Date: _____

_____
Signature of Witness

Name:_____

NRIC No : _____

Date : _____

_____
Authorized Signature of Contract Holder & Company's Stamp

Full Name :_____

Designation: _____

Date :_____

Contact No._____

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 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 Participant") and to provide such information to Etiqa Family Takaful 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 : _____

_____
Signature of Contract holder (If Participant is a minor)

Name : _____

NRIC : _____

Old IC : _____

Tel No. : _____

Date : _____

Etiqa Family Takaful Berhad (266243D)
(Formerly known as Etiqa Takaful Berhad)
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