

ACCIDENT 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.

Policy No:

Broker/ Account Manager's Name :

Broker/ Account Manager's Contact No. :

Instruction – Supporting documents required

- Accident Claim Form
- Accident Statement of Medical Examiner
- Certified copy of Hospital Discharge Summary (if hospitalised)
- Original or certified copy of Medical Certificate (MC) and Light Duty Certificate duly endorsed by doctor due to accident
- Certified copy of Life Assured and/or Claimant's IC
- X-ray report / Radiologist report for cases with fracture bones
- Photograph of dismemberment / amputation (if any)
- Police report (if any)

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. Particulars of 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 injury :
- viii. Address of the clinic / hospital :
- ix. Contact no. of the clinic / hospital :

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

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

Name, address and contact no. of the Life Assured's regular doctor other than above :

.....

5. 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 :

<u>Name of Company</u>	<u>Policy No.</u>	<u>Type of Coverage</u>	<u>Amount of Compensation (RM)</u>	<u>Date which the policies were effected</u>
------------------------	-------------------	-------------------------	------------------------------------	----------------------------------------------

.....

6. 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 Life Assured 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 Life Assured
Stamp

Signature of Witness

Authorized Signature of Policy Holder & Company's

Name:.....

Name :.....

Full Name :

Date :

NRIC No :

Designation: -

Date :

Date :

Contact No.



LETTER OF AUTHORISATION / CONSENT

To Obtain Further Medical information

TO WHOM IT MAY CONCERN

Name of Life Assured

NRIC No.(New)(Old)

Policy No.

I,, NRIC No. hereby authorize and give my consent to any medical practitioner, physician, surgeon, nurse, medical staff, clinic, hospital, medical centre, insurance company or organization or individual concerned ("the information provider") that may have any record or knowledge of health or medical history of the above stated ("Life Assured") and to provide such information to Etiqa Life Insurance Berhad and its authorized service provider and/or its employees in order to process my insurance claim.

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 arise, in supplying such information requested by the Company.

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

.....
Signature of Life Assured / Claimant (If Life Assured is a minor)

Name:

Relationship with Life Assured :

Date: