CRITICAL ILLNESS 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.

Policy No : _____

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

Instruction – Supporting documents required

- ☐ Critical Illness claim form
- ☐ Certified copy of Life Assured and/or Claimant's IC
- ☐ Critical Illness - Statement of Medical Examiner (Stroke / Heart / End Stage Renal failure / Cancer / Others)
- ☐ Relevant diagnostic test results or report to support the diagnosis (Please refer page 4-5)
- ☐ Original certificate/policy contract
- ☐ Other supporting document (if applicable)

Name of Life Assured _____

New IC No _____ Old IC No. _____ Age _____

Correspondence Address _____

_____

Mobile Phone No. _____ E-mail address _____

Phone No. _____ Fax No. _____

Name of the Employer _____

Address of the Employer _____

_____ Office Phone No. _____

Date of Employment _____ (dd/mm/yyyy)

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

_____

2 Date symptoms **first** commenced _____ (dd/mm/yyyy)

3 Date you **first** consulted doctor for this condition _____ (dd/mm/yyyy)

4 Name & address of doctor you **first** consulted for this condition _____

_____

5 What was the diagnosis? _____

6 What treatment are you currently receiving? _____

7 Have you previously sufferred from, or received treatment for a similar or related illness? ☐ Yes ☐ No

If yes, please give full details _____

8 State the name and address of your regular doctor _____

_____

9 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

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

If yes, please give details:

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

11 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 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.

I hereby declare that the foregoing answers and statements on the Participant are complete and true to the best of my knowledge and belief.

Signature / Thumb print of Life Assured

Name _____

Date _____ (dd/mm/yyyy)

Signature / Thumb print of Claimant (if other than Life Assured)

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 Policy Holder & Company's Stamp

Full name _____

Designation: _____

Contact No _____

Date _____

LETTER OF AUTHORISATION / CONSENT
TO OBTAIN FURTHER INFORMATION (LIVING ASSURANCE 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 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 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 _____ (dd/mm/yyyy)

_____

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

Name _____

NRIC _____

Old IC _____

Tel No _____

Date _____ (dd/mm/yyyy)

Etiqa Life Insurance Berhad (1239279-P)
(Licensed under Financial Services Act 2013 and regulated by Bank Negara Malaysia)
Level 17, Tower B, Dataran Maybank, No 1, Jalan Maarof, 59000 Kuala Lumpur
Etiqa Oneline 1300 13 8888 E info@etiqa.com.my
Etiqa Healthcare 1800 88 9888 F 1800 22 9988 E etiqahealthcare@etiqa.com.my www.etiqa.com.my
Ahli Kumpulan Maybank

Additional Requirements For Critical Illness Claim

Critical Illness	Additional Required Medical Evidence
Stroke	1. CT Scan / MRI of Brain report 2. Doctor's Statement to be completed by Consultant Neurologist (for current condition at least 6 months after the stroke)
Heart Attack	1. Cardiac Enzymes Assay results (CK-MB) 2. Electrocardiography report (ECG) 3. Tropinin T result, if any 4. Doctor's Statement to be completed by Consultant Cardiologist
End Stage Kidney Failure	1. Dialysis appointment card / receipts 2. Blood test results 3. Doctor's Statement to be completed by Consultant Nephrologist
Cancer	1. Histopathology/biopsy report (where applicable) 2. Bone Marrow Aspiration report (leukemia) 3. CT Scan / MRI report (where applicable)
Coronary Artery By-Pass Surgery	1. Coronary Artery By-Pass Surgery Report
End Stage Liver Failure	1. Liver Function Test 2. CT Scan of Liver 3. All laboratory, pathology, hepatitis screening, ultrasound & histology report
Fulminant Viral Hepatitis	1. CT Scan report of Liver 2. Liver Function Test results 3. Any other laboratory or pathology reports
Coma	1. Medical receipt for the usage of life support (Oxygen) 2. Doctor's Statement to be completed by Consultant Neurologist
Benign Brain Tumour	1. CT Scan / MRI of Brain report 2. Histopathology/biopsy report
Paralysis / Paraplegia	1. X-ray / CT Scan / MRI report, if available 2. Doctor's Statement to be completed by Consultant Neurologist
Blindness / Total Loss of Sight	1. Visual Acuity report on both eyes to be done by an ophthalmologist 2. Doctor's Statement to be completed by an Ophthalmologist
Deafness / Total Loss of Hearing	1. Audiometry test and Sound Threshold test results
Major Burns	1. Total Body Surface Assessment report
End Stage Lung Disease	1. Pulmonary Function test 2. FEV 1 test 3. Relevant medical reports
Encephalitis	1. CT Scan / MRI of Brain 2. Doctor's Statement to be completed by Consultant Neurologist
Major Organ / Bone Marrow Transplant	1. Surgery report
Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease	1. Coronary Angiogram report 2. Surgery report
Loss of Speech	1. Medical evidence from ENT specialist to confirm illness or injury to vocal cords 2. Doctor's Statement to be completed by speech pathologist / therapist
Brain Surgery	1. Brain Surgery report
Heart Valve Surgery	1. Heart Valve Surgery report

Critical Illness	Additional Required Medical Evidence
Terminal Illness	1. All relevant investigation result in support of the diagnosis
Bacterial Meningitis	1. CT Scan / MRI of Brain & Spine
Major Head Trauma	1. Detailed medical assessment from attending doctor 2. CT Scan / MRI of Brain 3. Police report, if any
Other Serious Coronary Artery Disease	1. Coronary Angiogram report
Chronic Aplastic Anaemia	1. Bone Marrow Aspiration 2. Blood test report
Motor Neuron Disease	1. All investigation reports
Parkinson's Disease	1. Detailed medical assessment including Activities of Daily Living from Consultant Neurologist
Muscular Dystrophy	1. Diagnostic test result 2. Doctor's Statement to be completed by Consultant Neurologist
Surgery to Aorta	1. Aorta Surgery report
Multiple Sclerosis	1. Ophthalmologist's report 2. CT Scan & MRI report of Brain & Spine 3. Doctor's Statement to be completed by Consultant Neurologist
Medullary Cystic Disease	1. Abdominal Ultrasound or Abdominal CT Scan 2. Renal biopsy report 3. Urine Specific Gravity Test 4. Blood test result 5. All clinical and laboratory investigation report
Severe Cardiomyopathy	1. Chest X-ray 2. Echocardiogram report
SLE with Lupus Nephritis	1. Urine test results 2. Blood test results 3. Kidney biopsy report
Primary Pulmonary Arterial Hypertension	1. All clinical and laboratory investigation including cardiac catheterization
Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders	1. Diagnostic test results
Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection	1. HIV antibody test by ELISA method within 7 days of the event/accident 2. HIV antibody test by ELISA method 6 months from date of blood transfusion 3. Statement from statutory Health Authority to confirm that the disease was occupationally acquired 4. Western Blot test