

## Hospital Confinement Claim Form

**Important Notice:**

- The participant/ claimant must give complete and accurate information.
- For your easy accessibility, this claim form is made available at our website [www.etiqa.com.my](http://www.etiqa.com.my)

### Information on Participant

Certificate No.:				
Name of Participant:				
MyKad / Army / Police / Passport no./ Business registration no.:			Occupation:	
Contact details	Phone no.	Mobile:	House:	Office:
	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:
	Email:			
Address				
Postcode		Town	State	Country
Relationship of patient to policyholder:				

### Claim information

If due to <b>sickness</b> , please provide full details of the disease:			
Date symptom first presented (dd/mm/yyyy):			
Have you ever suffered from this symptom before?	<input type="checkbox"/> Yes, when (dd/mm/yyyy):	<input type="checkbox"/> No	
If <b>accident</b> , 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?	<input type="checkbox"/> Yes, please provide:	<input type="checkbox"/> 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 Takaful 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 participant  
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:	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury
Diagnosis:		
If <b>injury</b> , when did the accident occurred?		
Do you think that the patient was intoxicated by alcohol or drug at the time of accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If <b>sickness</b> , 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?	<input type="checkbox"/> Yes, please provide details:	<input type="checkbox"/> No
Are you the patient usual medical attendant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient ever sought treatment for this condition elsewhere other than you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Name of doctor:	
	Name of hospital / clinic:	
Have any investigations, tests or procedures been performed?	<input type="checkbox"/> Yes, please provide details:	<input type="checkbox"/> No
Has biopsy been done to confirm whether the cells/ tissues are cancerous? <i>(for cancer patient only)</i>		
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.: