

GROUP CLAIMS CLAIMANT STATEMENT FORM

GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

Type of Claims

Note: Please tick (✓) the relevant claims type & refer to Claims Checklist for list of required supporting documents for submission

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hospitalisation Benefit (HB) | <input type="checkbox"/> Total Permanent Disability | <input type="checkbox"/> Terminal Illness | <input type="checkbox"/> Accidental Death |
| <input type="checkbox"/> Critical Illness | <input type="checkbox"/> Partial Permanent Disability | <input type="checkbox"/> AIR Weekly Indemnity | <input type="checkbox"/> Death <input type="checkbox"/> Funeral |

Section A: Details of Life Assured / Deceased

Policy No				
Name of Policyholder				
Name of Insured Person				
MyKad No. OR Other ID No.				
Contact Details	Phone	Mobile:	House:	Office:
	Fax No.		Email	
Current Corresponding Address				
	Postcode	Town:	State:	
Current Occupation & Job Nature				

Section B: Details of Claimant

Relationship with Insured Person	<input type="checkbox"/> Own	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Parent
	<input type="checkbox"/> Employer	<input type="checkbox"/> Contract Holder	<input type="checkbox"/> Others (Please specify: _____)	
Name				
MyKad No. OR Other ID No.			Benefit Sum Assured <small>(Applicable for Employers only)</small>	RM
Contact Details	Phone	Mobile:	House:	Office:
	Fax No.		Email	
Current Corresponding Address				
	Postcode:	Town:	State:	
Bank Account Details <small>(Current or Savings Account)</small>	Bank Name			
	Bank Account Holder Name			
	Account Type	<input type="checkbox"/> Current	<input type="checkbox"/> Savings	
	Account Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Section C: Details of Claims

Claim Type : Death/ Accidental Death /Funeral Expenses Claim

Date of Death (dd/mm/yyyy)		Last Working Date (If employed)	
Any Post Mortem Done?		<input type="checkbox"/> Yes (Please provide copy of the report) <input type="checkbox"/> No	

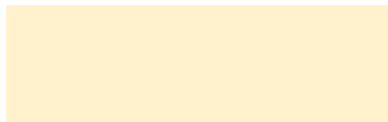
Claim Type : Hospitalisation /Critical Illness/ Terminal illness /AIR Weekly Indemnity Claim			
Date of Admission (dd/mm/yyyy)		Date of Discharge (dd/mm/yyyy)	
Admitted Hospital			
Diagnosis			
First Date of Signs & Symptom for the Diagnosis (dd/mm/yyyy)		Medical Certificate (MC) Dates (dd/mm/yyyy)	
Date of Accident (dd/mm/yyyy)		Place of accident	

Claim Type : Total / Partial Permanent Disability Claim			
Date of Admission (dd/mm/yyyy)		Date of Discharge (dd/mm/yyyy)	
Diagnosis			
First Date of Signs & Symptom for the Diagnosis (dd/mm/yyyy)		Medical Certificate (MC) Dates (dd/mm/yyyy)	
Date of MC/ Prolonged Illness Leave	Start Date (dd/mm/yyyy):	End Date (dd/mm/yyyy):	
Current Salary Status	<input type="checkbox"/> Full Salary	<input type="checkbox"/> Half Salary	<input type="checkbox"/> No Salary
Last Drawn Monthly Basic Salary	Paid Date (dd/mm/yyyy)		Salary Amount RM
Last Working Date (dd/mm/yyyy)		Date of Resignation /Medically Boarded out / Early Retirement (if any)	

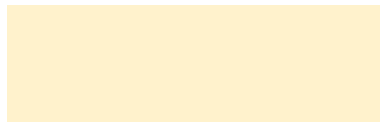
DECLARATION

I do solemnly and sincerely declare that I am the nominee/administrator/beneficiary for the Insurance benefit of the deceased and further declare as follows:-

- That the foregoing answers and statements on the Deceased are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
- That any difference, if any, in respect of the details contained in the enclosed supporting document and the information presented to Etiqa Life Insurance Berhad (Etiqa) in this form refers to the same person. I understand and agree that Etiqa has the sole discretion to reject this application if the information given is false or insufficient.
- That the original certificate whether or not enclosed therein (if any), due to loss or mutilated, belongs to the person covered.
- And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish Etiqa or its representative any information that may be required concerning my health conditions, for settlement of this claim. I agree that Etiqa 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, agree, consent and allow Etiqa (hereinafter called to process my personal data (including sensitive personal data) ('Personal Data') with the intention of processing this Claim Form, in compliance with the provisions of the Personal Data Protection Act 2010.
- I, understand and agree that any Personal Data collected or held by Etiqa contained in this Claim Form may be held, used, processed and disclosed by Etiqa to individuals and/or organizations related to and associated with Etiqa or any selected third party (within or outside Malaysia, including medical institutions, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this Claim Form and providing subsequent service related to it and to communicate with me for such purposes.
- I agree that a copy of documents submitted shall be as valid as the original. I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.



Signature/ Thumbprint of claimant
Name:
Date



Official Stamp with designation of (For Policyholder)
Date: