TAKAFULmalaysia

Syarikat Takaful Malaysia Berhad (131646-K)
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FOR OFFICE USE	
CLAIM FORM NO:	
DATE RECEIVED:	
OFFICE IN-CHARGE	
SERVICING BRANCH	
NOTIFICATION NO:	

The issuance and acceptance of this claim form is not an admission of liability by the Company and if false statements or declarations be made in support of this claim, this claim shall be null and void. Please complete this claim form in full in CAPITAL LETTERS and cross [x] the boxes as appropriate. /
Pengeluaran dan penerimaan borang tuntutan ini bukan pengakuan liabiliti oleh pihak Syarikat dan sekiranya kenyataan dan pengisytiharan palsu dibuat untuk menyokong tuntutan ini, maka tuntutan ini adalah dianggapbatal dan tidak sah. Sila lengkapkan borang tuntutan ini sepenuhnya dengan HURUF BESAR dan pangkah [x] pada kotak-kotak di mana perlu.

PERSONAL ACCIDENT TAKAFUL CLAIM FORM/BORANG TUNTUTAN TAKAFUL KEMALANGAN DIRI

Part 1: Details of Participant/*Bahagian 1: Butir-butir Peserta*

1. Takaful Certificate No/No Sijil Takaful

2. Name/Name

3. New NRIC No/No KP Baru

   Old IC No/Passport No/ Company Registration No/
   No KP Lama/No Pasport/
   No Pendaftaran Syarikat

4. Correspondence Address/Alamat Surat-menyurat

   Postcode/Poskod

5. Telephone /Telefon - Handphone/Telefon Bimbit - Facsimile No/No Faksimili -

6. E-mail Address /Alamat E-mel

Part 2: Type of Claims/*Bahagian 2: Jenis Tuntutan*

- ☐ Death due to accident/ Kematian akibat kemalangan
- ☐ Permanent disability due to accident/Keilatan kekal akibat kemalangan
- ☐ Temporary disability due to accident/Keilatan sementara akibat kemalangan
- ☐ Medical expenses/ Perbelanjaan perubatan
- ☐ Medical expenses/ Perbelanjaan perubatan

Part 3: Details of the Injured Person/*Bahagian 3: Butir-butir Pihak Yang Mengalami Kecederaan*

1. Name of owner/ Nama pemilik

2. New NRIC No/No KP Baru

   Old IC No/Passport No/ Company Registration No/
   No KP Lama/No Pasport/
   No Pendaftaran Syarikat

3. If this person is not the participant/member/employee of the participant, please state his/her relationship to the participant/member/employee of the participant/ Sekiranya pihak yang mengalami kecederaan bukanlah peserta/ahli/kakitangan peserta, sila nyatakan perhubungan beliau dengan peserta/ahli/kakitangan peserta

4. Details of the injuries and disabilities as confirmed by the attending physician/
   Butir-butir kecederaan dan keilatan sebagaimana yang disahkan oleh pegawai perubatan yang merawat

5. Name of attending physician, hospital and address/
   Nama pegawai perubatan yang merawat, hospital dan alamat

Part 4: Details of the Accident/*Bahagian 4: Butir-butir Kemalangan*

1. Date of incident (DD/MM/YYYY) / Tarikh kejadian (HH/BB/TTTT) / / Time/ Masa : AM/PM

2. Please describe in your own word show the incident occurred. Please do not state "Please refer to the Police Report" or "Please refer to the Medical Report"/*Dengan perkataan anda sendiri, terangkan bagaimana kejadian tersebut berlaku. Sila jangan nyatakan "Sila rujuk kepada Laporan Polis" atau "Sila rujuk kepada Laporan Perubatan" di dalam penerangan anda.*

3. Did the injured person suffer any injuries or disabilities or illness prior to this accident? If YES, please describe the nature of the injuries or disabilities or illness and the date it was first diagnosed /Adakah pihak yang mengalami kecederaan juga telah mengalamis ebarang kecederaan atau keilatan atau mengidap sebarang penyakit sebelum kemalangan tersebut berlaku?Jika YA, terangkan denganjelas jenis kecederaan atau keilatan atau penyakit yang dialami dan tarikh ianya mula diketahui.

Part 5: Other Takaful/Insurance Covers/*Bahagian 5: Perlindungan Takaful/Insurans Lain*

1. Is the injuries/disabilities/loss aspect of which you are making claims are covered by other takaful operator or insurance company against all or any of the risks covered by this certificate?/Adakah kecederaan/keilatan/kehilangan yang menjadi asas tuntutan anda juga dilindungi oleh pengendali takaful lain atau syarikat insurans bagi semua atau mana-mana risiko yang dilindungi oleh sijil ini?

   - ☐ Yes, please specify details/ Ya, sila nyatakan maklumat lengkap
   - ☐ No/ Tidak

Part 6: Details of Medical Treatment/*Bahagian 6: Butir-butir Rawatan Perubatan*

Please state summary of medical treatment received related to the injuries and disabilities/Sila nyatakan maklumat rawatan perubatan yang diterima berkaitan kecederaan dan keilatan yang dialami

Hospital's name and location /Nama hospital dan lokasi	Date of admission /Tarikh dimasukkan ke hospital

Part 7: Details of Medical Leave/*Bahagian 8: Butir-butir Cuti Sakit*

1. Dates of medical leave/Senaraikan tarikh-tarikh anda diberikan cuti sakit _____

2. Dates of light duty leave/Senaraikan tarikh-tarikh anda diberikan cuti kerja ringan _____

3. Date when the employment was terminated (DD/MM/YYYY), if applicable / Tarikh ditamatkan perkhidmatan (HH/BB/TTTT), sekiranya berkenaan ☐☐ /

Part 8: Details of Claimant/*Bahagian 8: Butir-butir Pihak Yang Menuntut*

Please complete the following details if the Claimant is other than the Participant/Sila lengkapkan butir-butir berikut sekiranya Pihak Yang Menuntut selain daripada Peserta

1. Name of owner/ Nama pemilik

2. New NRIC No/No KP Baru ☐☐☐☐☐☐ ☐☐ ☐☐☐☐

   Old IC No/Passport No/ Company Registration No/ No KP Lama/No Pasport/ No Pendaftaran Syarikat

3. Relationship to the Participant/Hubungan dengan Peserta _____

Part 9: Details of Claimant/*Bahagian 9: Butir-butir Pihak Yang Menuntut*

I herebyauthoriseanyhospitals, surgeons ,medical practitioners or clinics or other persons who have attended or examined me or my child for any reasons to disclose any and all information with respect to any illnesses or injuries and to provide copies of all medical reports, including earlier medical history. A copy of this authorisation shall be considered as effective and valid as the original./*Bahawasanya dengan ini, saya/kami membenarkan mana-mana hospital, pakar bedah, pegawai perubatan atau klinik atau orang perseorangan lain yang pernah merawat atau memeriksa saya atau anak saya atas apa jua sebab, untuk memberikan sebarang dan semua maklumat berkaitan penyakit atau kecederaan dan menyediakan salinan laporan perubatan termasuk sejarah perubatan terdahulu. Salinan kebenaran ini hendaklah juga dianggap sebagai sah sepertimana salinan asalnya.*

☐☐ / ☐☐ / ☐☐☐☐

Date (DD/MM/YYYY)/Tarikh (HH/BB/TTTT)

_____

Signature of the injured Person or his/her guardian
Tandatangan Pihak Yang Mengalami Kecederaan atau penjaganya

Part 10: Declaration by Participant and/or Claimant/*Bahagian 10: Perakuan Peserta dan/atau Pihak yang Menuntut*

I/We hereby declare that, to the best of my/our knowledge, the above statements and facts are true and I/we did not falsify or provide any false statements to support this claim./*Bahawasanya dengan ini adalah saya/kami sepanjang pengetahuan saya/kami mengesahkan pernyataan-pernyataan yang terkandung diatas adalah benar dan betul dan saya/kami tidak memalsukan atau memberikan pernyataan yang tidak benar bagi menyokong tuntutan tersebut.*

If this form was completed by someone else, I/we hereby declare that all statements provided by them to be considered as statements provided by me/us and I/we shall be fully responsible for those statements./*Sekiranya borang ini diisi oleh orang lain bagi pihak saya/kami maka saya/kami mengaku bahawa apa-apa pernyataan yang dibuat oleh mereka adalah disifatkan sebagai pernyataan saya/kami sendiri dan saya/kami mengaku bertanggungjawab ke atas pernyataan-pernyataan tersebut.*

I/We also declare that we shall fully cooperate with the Company and any other parties representing the Company in relation to this claim./Saya/*Kami seterusnya mengaku akan memberi kerjasama yang penuh dan sepatutnya kepada pihak Syarikat serta mana-mana pihak lain yang mewakili pihak Syarikat bersabit dengan tuntutan ini.*

☐☐ / ☐☐ / ☐☐☐☐

Date (DD/MM/YYYY)/Tarikh (HH/BB/TTTT)

_____

Participant's Signature /Tandatangan Peserta
(Please affix Official Seal, if applicable) /
(Sila letakkan Cop Rasmi, jika berkenaan)

_____

Claimant's Signature/
Tandatangan Pihak Yang Menuntut

Part 11: Verification of Identity/*Bahagian 11: Pengesahan Pengenalan*

I hereby certify that the participant's and claimant's original NRIC/Company Registration Certificate was verified and authenticated by me at the point of claim submission./ *Saya dengan ini mengesahkan bahawa salinan asal kad pengenalan (KP)/Sijil Pendaftaran Syarikat peserta dan pihak yang menuntut telah disahkan ketulenannya ketika permohonan tuntutan dibuat.*

Third Party Verification /Pengesahan Pihak Ketiga:

Name/Nama _____

Signature/Tandatangan _____

New NRIC No/No KP Baru ☐☐☐☐☐☐ ☐☐ ☐☐☐☐

Date (DD/MM/YYYY)/Tarikh (HH/BB/TTTT) ☐☐ / ☐☐ / ☐☐☐☐

"Third Party' means takaful agents, takaful brokers or staff of the Company./"Pihak Ketiga" bermaksud ejen takaful, broker takaful atau kakitangan pihak Syarikat.

Important Notice/*Notis Penting*

Please submit the following documents to support your claim/Sila sertakan dokumen-dokumen di bawah untuk menyokong tuntutan anda

- ☐ Personal Accident Takaful Claim Form duly completed/ Borang Tuntutan Takaful Kemalangan Diri yang lengkap diisi
- ☐ Copy of Identity Card/Company Registration Certificate/ Salinan Kad Pengenalan/Sijil Pendaftaran Syarikat
- ☐ Copy of Police Report/ Salinan Laporan Polis
- ☐ Copy of Medical Report, if any/ Salinan Laporan Perubatan, sekiranya ada
- ☐ Copy of Medical Specialist Report, if any/ Salinan Laporan Perubatan Pakar, sekiranya ada
- ☐ Copy of Death Certificate (for fatal accident only)/ Salinan Sijil Kematian (untuk kemalangan maut sahaja)
- ☐ Copy of Post Mortem report, if any/ Salinan Laporan Bedah Siasat, sekiranya ada

Please note that the Company may require additional supporting documents to be submitted after the claim has been registered/
Sila ambil maklum bahawa pihak Syarikat mungkin memerlukan dokumen-dokumen tambahan lain untuk diserahkan setelah tuntutan ini didaftarkan.

For all intents and purpose where there is a conflict or ambiguity as to the meaning in the Bahasa Malaysia provisions, it is hereby agreed that the English version shall prevail. / Bagi setiap tujuan dan maksud sekiranya terdapat konflik atau kekaburan berkenaan makna di dalam peruntukan Bahasa Malaysia, adalah dipersetujui bahawa versi Bahasa Inggeris akan digunapakai.

MEDICAL CERTIFICATION FOR INJURIES AND DISABILITIES

THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN.
Please Use Separate Sheet Of Paper If Additional Space Is Required.

A. DIAGNOSIS

1.	Date and time of the accident, and to your knowledge how was the accident happenned?				
2.	Full details of the injuries				
3.	Are these injuries consistent with the circumstances of the accident as described to you?				
4.	Is there any previous medical history or disablement which might have contributed to the occurrence of the accident, or which way retard/prolong the recovery?				
5.	To your knowledge, was the patient suffering from any disease or injuries or disabilities at the time of the accident?				
6.	Was the patient being referred to you from another clinic/hospital? If YES, please state the referring hospital/clinic's address and telephone number.				
7.	Has the patient suffered any previous episodes of this condition or any condition leading to it or relating to it? If YES, please provide the details.	Date	Symptoms	Diagnosis	Treatment
8.	Has the patient under gone any surgical procedures for this condition or any condition leading to it or relating to it? If YES, please provide the details.	Date	Hospital	Diagnosis	Surgical Procedures

B. INJURIES AND DISABILITIES

1.	What is the extent and severity of the patient's condition (eg. Is he/she able to commute by himself/herself? Is he/she able to concentrate on and complete the task by himself/herself, if so, for how long?)	
2.	Is the patient's condition improving, stable or deteriorating?	
3.	Is the patient's conditionp ermanent? If YES, please provide the estimated percentage of permanent disability against the 100% ability of its original function.	
4.	What is the extent of the patient's expected recovery from this condition?	
5.	When would the recovery be expected?	
6.	To what extent would the patient's current condition affect his/her ability to perform his/her usual occupation?	
7.	To what extent would the patient's ability to perform his/her usual occupation be affected after his/her expected recovery?	
8.	To what extent would the patient's current condition affect his/her ability to perform any other occupation?	
9.	To what extent would the patient's ability to perform any other occupation be affected after his/her expected recovery?	
10.	Is the patient capable of practising current occupation on a full-time or part-time basis?	
11.	Is the patient capable of practising other occupation? If yes, please describe type of work?	

THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN.
Please Use Separate Sheet Of Paper If Additional Space Is Required.

C. ACTIVITIES OF DAILY LIVING: Please comment on whether the patient is able to perform the following activities of daily living

WASHING, BATHING Ability tow ash or bath or showeron by other means to maintain personal cleanliness	☐ Yes ☐ No	Comments:
DRESSING Ability to dress and undress and to put on and take off any medical appliances usually worn	☐ Yes ☐ No	Comments:
TOILETING Ability to do all of the following: to get to and from the lavatory, to get on and off the lavatory, to maintain adequate level of personal hygiene	☐ Yes ☐ No	Comments:
CONTINENCE Ability to voluntarily control bowel and bladder function with or without the use of catheters, incontinence or other artificial aids	☐ Yes ☐ No	Comments:
FEEDING Ability to take any form of nourishment once it had been prepared and made available	☐ Yes ☐ No	Comments:
MOBILITY Ability to move in and out of a chair or bed	☐ Yes ☐ No	Comments:
Restriction in movement or lifestyle? **If so, please give details**	☐ Yes ☐ No	Comments:

D. CERTIFICATION OF DISABILITIES

TEMPORARY PARTIAL DISABLEMENT

I hereby certify that the patient hass uffered temporary partial disablement due to the above condition and has been able to performonly light duties of his usual duties or jobs during the following periods:

From: ☐☐ / ☐☐ / ☐☐☐☐
To: ☐☐ / ☐☐ / ☐☐☐☐

TEMPORARY TOTAL DISABLEMENT

I hereby certify that the patient has suffered temporary total disablement du eto the above condition and has not been able to perform any of his usual duties or jobs during the following periods:

From: ☐☐ / ☐☐ / ☐☐☐☐
To: ☐☐ / ☐☐ / ☐☐☐☐

PERMANENT PARTIAL DISABLEMENT

I hereby certify that the patient has suffered permanent partial disablement due to the above condition and the details are as follows:

Percentage of disability: ☐☐ %

Please state which limbs and details of its disablement

_____

_____

_____

PERMANENT TOTAL DISABLEMENT

I hereby certify that the patient has suffered permanent total disablement due to the above condition and the details are as follows:

Please state which limbs and details of its disablement

_____

_____

_____

Please provide additional information, if any:

E. DECLARATION BY THE ATTENDING PHYSICIAN

To the best of my knowledge, I hereby declare that all the information given above are true and accurate.

Name of patient: _____

NRIC/BC/Passport No: _____ MRN: _____

Signature of Attending Physician: _____ Professional Qualifications: _____

Name: _____

Address: _____

_____

_____

_____