Takafulmalaysia

FOR OFFICE USE

CLAIM FORM NO. :	
DATE RECEIVED:	
OFFICER IN-CHARGE:	
SERVICING BRANCH:	
NOTIFICATION NO:	

HEAD OFFICE/ *IBU PEJABAT:* **Syarikat Takaful Malaysia Keluarga Berhad** [198401019089 (131646-K)]
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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 dianggap batal dan tidak sah. Sila lengkapkan borang tuntutan ini sepenuhnya dengan HURUF BESAR dan pangkah [x] pada kotak yang berkenaan.

CRITICAL ILLNESS CLAIM FORM / *BORANG TUNTUTAN PENYAKIT KRITIKAL*

PART 1 : DETAILS OF PERSON CRITICAL ILLNESS / *BAHAGIAN 1 : BUTIR-BUTIR PIHAK YANG MENGHIDAP PENYAKIT KRITIKAL*

Takaful Certificate No / *No Sijil Takaful*

1	Name / *Nama*	
2	Occupation/*Pekerjaan*	3. Employer/*Majikan*
4	MyKad No. / *No. MyKad*	– – Old IC No. / Birth Certificate No. / Passport No. / *No. KP Lama / No. Sijil Kelahiran* / No. *Pasport*
5	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*	

PART 2 : DETAILS OF ILLNESS / *BAHAGIAN 2 : BUTIR – BUTIR PENYAKIT*

1	Exact diagnosis as certified by the attending doctor */ Butir penykit seperti yang disahkan oleh doktor yang merawat*	
2	Date when the symtom was first diagnosed (DD/MM/YYYY) / *Tarikh penyakit/kecederaan tersebut mula dikesan (HH/BB/TTT)*	– –
3	Date of first hospital admission (DD/MM/YYYY) / *Tarikh kali pertama dimasukkan ke hopital (HH/BB/TTT)*	– –
4	Name and Address of all medical practitioners that have been consulted for this condition / *Nama dan alamat semua pegawai perubatan yang dirujuk untuk penyakit/kecederaan ini*	
10	Is this condition related to pregnancy, abortion, miscarriage, sterilisation, sub-fertility, infertility, self-inflicted injury, sexually transmitted disease, congenital anomaly, nervous or mental disorder, cosmetic reasons or work-related injury? / *Adakah penyakit/kecederaan ini berkaitan dengan kehamilan, pengguguran, keguguran, kemandulan, kesuburan, ketidaksuburan, kecederaan yang disengajakan, penyakit kelamin, kecacatan sejak lahir, masalah mental, rawatan kosmetik atau kecederaan berkaitan pekerjaan?*	☐ Yes / *Ya* ☐ No / *Tidak*

PART 3: DETAILS OF THE ACCIDENT / *BAHAGIAN 3: BUTIR-BUTIR KEMALANGAN*

Please complete the following details if the illness/injury was due to accident. / *Sila lengkapkan butir-butir berikut sekiranya penyakit/kecederaan yang dialami adalah disebabkan oleh kemalangan.*

1	Date of incident (DD/MM/YYYY) / *Tarikh kejadian (HH/BB/TTTT)*	– – Time / *Masa* : AM /PM
2	Please describe in your own words the nature and extent of the injuries suffered due to this accident and medical treatment received, Please do not state "Please refer to the Police Report" or " Please refer to the Medical report". */Dengan perkataan anda sendiri, terangkan kecederaan yang telah dialami akibat kemalangan tersebut serta nyatakan rawatan yang telah diterima. 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 illness or disabilities and the date it was first diagnosed. /*Adakah pihak yang mengalami kecederaan juga telah mengalami sebarang kecederaan atau keilatan atau menghidap sebarang penyakit sebelum kemalangan tersebut berlaku? Jika YA, terangkan dengan jelas jenis kecederaan atau keilatan atau penyakit yang dialami dan tarikh ianya mula diketahui.*	

PART 4 : DETAILS OF ILLNESS / *BAHAGIAN 4 : BUTIR – BUTIR PENYAKIT*

Please complete the following details if payment is to be made to beneficiary / *Sila lengkapkan butir-butir berkut sekiranya bayarandibuat ke atas waris.*

1	Name / *Nama*	
2	Occupation/*Pekerjaan*	3. Employer/*Majikan*
4	MyKad No. / *No. MyKad*	– – Old IC No. / Birth Certificate No. / Passport No. / *No. KP Lama / No. Sijil Kelahiran* / No. *Pasport*
5	Relationship to Participant / *Hubungan dengan Peserta*	

PART 5: MEDICAL INFORMATION AUTHORISATION / *BAHAGIAN 5: KEBENARAN MAKLUMAT PERUBATAN*

I hereby authorise any hospitals, 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 in- formation 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 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 temasuk sejarah perubatan terdahulu. Salinan kebenaran ini hendaklah juga dianggap sebagai sah sepertimana salinan asalnya.*

– –

Date (DD/MM/YYYY) /*Tarikh (HH/BB/TTT)*

Signature of person with critical illness or his/her guardian
Tandatangan pihak yang menghidap penyakit kritikal atau penjaganya

PART 6: DECLARATION BY PARTICIPANT AND/OR CLAIMANT / *BAHAGIAN 6: 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 di atas 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, /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/TTT)*

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

PART 7: VERIFICATION OF IDENTITY / *BAHAGIAN 7: 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:*

New NRIC No / *No. KP Baru*

– –

Name / *Nama:* ____________________

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

– –

Signature/*Tandatangan* ____________________

"Third Party' means takaful agents, takaful brokers or staff or 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*

- ☐ Critical Illness Takaful Claim Form duly completed / *Borang Tuntutan Penyakit Kritikal yang lengkap diisi*
- ☐ Certified true copy of Participant's Identity Card / *Salinan Kad Pengenalan yang disahkan*
- ☐ Medical Report / *Laporan Perubatan*
- ☐ All Labs and Investigation Report / *Laporan Makmal dan Siasatan*
- ☐ Certified true copy of Participant's Identity Card / *Salinan Kad Pengenalan yang disahkan*

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. Direct Credit Instruction / Arahan Pindahan Terus*

DIRECT CREDIT INSTRUCTION / *ARAHAN PINDAHAN TERUS*

Important Note : The account holder name and claimant must be the same person / ***Nota Penting :*** *Nama Pemegang Akaun dan penandatangan arahan kredit mestilah sama dengan penuntut pada borang tuntutan.*

e-Payment (Individual) / *e-Pembayaran (Individu)*

Name of Account Holder / *Nama Pemegang Akaun*	
MyKad / Passport No. / *No. MyKad / Pasport*	
Correspondence Address / *Alamat Surat Menyurat*	
Email Address / *Alamat Emel*	
Mobile No. / *No. Telefon Bimbit*	
Bank Name / *Nama Bank*	
Bank Account No. / *No. Akaun Bank*	
Signature / *Tandatangan*	Date / Tarikh:

Terms and Conditions / Terma-terma dan Syarat-syarat

1. Direct Credit facility is only applicable for bank accounts maintained in Malaysia. For overseas customers, we will assess and allow overseas accounts on a case to case basis. / *Kemudahan Kredit Terus hanya boleh digunakan bagi akaun bank yang diselenggara di Malaysia sahaja. Bagi pelanggan luar negara, kami akan menilai dan membenarkan penggunaan akaun luar negara berdasarkan kepada setiap kes.*

2. Direct Credit facility is applicable for Participant's / Certificate Owner's bank account only. Payment to other beneficiaries is to be considered on case by case basis. / *Kemudahan Kredit Terus Boleh digunakan untuk akaun bank Peserta / Pemilik Sijil sahaja. Pembayaran kepada penerima lain akan dipertimbangkan berdasarkan setiap kes.*

3. Participant / Certificate Owner is to furnish a copy of the bank passbook or bank statement and the IC no. / Passport no. that was used to open the bank account for verification purpose. / *Peserta / Pemilik Sijil perlu mengemukakan satu salinan buku simpanan bank atau penyata bank dan No. Kad Pengenalan / No. Pasport yang digunakan bagi membuka akaun bank untuk tujuan pengesahan.*

4. If the copy of bank passbook or bank statement is not provided, the Participant / Certificate Owner is deemed to have confirmed the account details provided in this form as valid and accurate. / *Jika salinan buku simpanan bank atau penyata bank tidak dikemukakan, Peserta / Pemilik Sijil dianggap telah mengesahkan bahawa butir-butir akaun di dalam borang ini adalah sahih dan tepat.*

   * In the event of any invalid / inaccurate account details provided by Participant / Certificate Owner results in payment being credited into a third party bank account, the payment made thereto is still deemed as full payment for Refund / Surrender/ Partial Withdrawal / Claims / Cancellation / Others and STMAB shall be released and fully discharged from all existing and future liabilities, claims and demands in relation to such Refund / Surrender / Partial Withdrawal / Claims / Cancellation / Others.

   * *Jika salinan buku simpanan bank atau penyata bank tidak dikemukakan, Peserta / Pemilik Sijil dianggap telah mengesahkan bahawa butir-butir akaun di dalam borang ini adalah sahih dan tepat. * Sekiranya butir-butir yang diberikan oleh Peserta / Pemilik Sijil tidak sah atau tidak tepat, mengakibatkan pembayaran Kredit Terus ke dalam akaun bank pihak ketiga, pembayaran dibuat itu masih dianggap pembayaran penuh bagi tujuan Bayaran Balik / Serahan / Pengeluaran Sebahagian / Tuntutan / Pembatalan / Lain-lain dan STMKB tidak akan bertanggungjawab atas segala liabiliti, dakwaan dan permintaan pada masa kini dan juga pada masa hadapan yang berkaitan dengan Bayaran Balik / Serahan / Pengeluaran Sebahagian / Tuntutan / Pembatalan / Lain-lain.*

MEDICAL CERTIFICATION FOR CRITICAL ILLNESS

THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN
Please use separate sheet of paper if additional space is required

A. GENERAL INFORMATION

Question	Answer
1. Are you the patient's regular medical attendant? If YES, for how long was the patient known to you?	
2. When were you first consulted for this condition?	
3. At that time, how long had the symptoms been present?	
4. When was the patient's condition first diagnosed?	
5. Approximately, when was the patient first become aware of the condition?	
6. When was the patient informed of the diagnosis?	
7. Was the patient referred to you from another clinic/hospital? If YES, please state the referring clinic/hospital's address and telephone number.	
8. Has the patient ever referred to Specialist for consultation or treatment? If YES, please provide the details.	
9. Has the patient suffered any previous episodes of this condition or any conditions leading to it or relating to it? If YES, please provide the details.	Date Symptoms Diagnosis Treatment
10. Has the patient undergone any surgical procedures for this condition or any condition leading to it or relating to it? If YES, please provide the details.	Date Symptoms Diagnosis Treatment

B. MEDICAL DETAILS

1. Details of the exact diagnosis.	

2. Please indicate whether the following documents are available. If YES, please provide a certified true copy of these documents to support the patient's application for critical illness claim.

a.	CT Scan report	☐ Yes	☐ No	n.	Kidney function test	☐ Yes	☐ No
b.	MRI report	☐ Yes	☐ No	o.	Hearing test report	☐ Yes	☐ No
c.	ECG report	☐ Yes	☐ No	p.	Gloscow report	☐ Yes	☐ No
d.	Radiological report	☐ Yes	☐ No	q.	Neuromotoe sensory report	☐ Yes	☐ No
e.	Histopathology report	☐ Yes	☐ No	r.	Burns report	☐ Yes	☐ No
f.	Haemotology report	☐ Yes	☐ No	s.	Laboratory investigation report	☐ Yes	☐ No
g.	Cardiax enzymes lab report	☐ Yes	☐ No	t.	Force ejection-fraction volume test	☐ Yes	☐ No
h.	Cardiac catheterisation report	☐ Yes	☐ No	u.	Blood tranfusion report	☐ Yes	☐ No
i.	Motor sensory test	☐ Yes	☐ No	v.	HIV test	☐ Yes	☐ No
j.	Neuro function test	☐ Yes	☐ No	w.	Other radiology report	☐ Yes	☐ No
k.	Motor Neuro report	☐ Yes	☐ No	x.	Other laboratory report	☐ Yes	☐ No
l.	Neurological report	☐ Yes	☐ No	y.	Operation report	☐ Yes	☐ No
m.	Liver function test	☐ Yes	☐ No	z.	Other investigation report	☐ Yes	☐ No

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

Activity	Yes / No	Comments
Washing, bathing Ability to wash or bath or shower or 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 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. 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: ____________________

Official Seal:

Date: ____________________