AmMetLife Insurance Berhad (15743-P)
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HOSPITALISATION & SURGICAL CLAIM FORM / *BORANG TUNTUTAN HOSPITAL & PEMBEDAHAN*

Hospitalisation Benefit (HB) / *Faedah Hospital (HB)*	☐	AmFamily Scheme / *Skim AmFamily*	☐
Health Management Rider (HMR) / *Faedah Pengurusan Hospital*	☐	Special Medicare / *Medicare Khas*	☐

Part I – CLAIMANT'S STATEMENT / *Bahagian I – KENYATAAN PENUNTUT*

Please enclose itemised original bills, official receipts covering hospitalisation & surgical expenses and Discharge note / *Sila kemukakan invois terperinci, resit asal mencatatkan perbelanjaan rawatan hospital dan Nota Keluar hospital.*

1. *Policy No. / **No. Polisi*

2. Life Assured's details / *Butir Diri yang DiInsuranskan*	3. Policy Owner's Details (if other than Life Assured) / *Butir Pemilik Polisi (jika selain daripada Diri yang DiInsuranskan)*
i) *Name of Life Assured / **Nama Diri yang DiInsuranskan*	i) *Name of Policy Owner / **Nama Pemegang Polisi*
ii) *NRIC No. / **No. K/P*	ii) *NRIC No. / **No. K/P*
iii) Correspondence address / *Alamat surat menyurat*	iii) Correspondence address / *Alamat surat menyurat*
iv) Nationality / *Warganegara*	iv) Nationality / *Warganegara*
v) Date of birth / *Tarikh Lahir*	v) Date of birth / *Tarikh Lahir*
vi) Occupation / *Pekerjaan*	vi) Occupation / *Pekerjaan*
vii) Name of Employer / *Nama Majikan*	vii) Name of Employer / *Nama Majikan*
viii) Nature of Business / *Jenis Perniagaan*	viii) Nature of Business / *Jenis Perniagaan*
viii) Employer's Address / *Alamat Majikan*	viii) Employer's Address / *Alamat Majikan*
ix) Telephone No. / *No. Telefon* Residence / *Rumah* : Office / *Pejabat*: Mobile No. / *Telefon Bimbit*:	ix) Telephone No. / *No. Telefon* Residence / *Rumah*: Office / *Pejabat*: Mobile No. / *Telefon Bimbit*:

4. If hospitalisation was due to <u>accident</u>, please provide details of accident / *Jika kemasukan ke hospital disebabkan <u>kemalangan</u>, sila beri butir kejadian kemalangan*
   i. When did it occur? / *Bilakah kemalangan tersebut berlaku?*
   ii. Where did it occur? / *Dimanakah kemalangan tersebut berlaku?*
   iii. How did it occur? / *Bagaimanakah kemalangan tersebut berlaku?*
   iv. Nature and extent of injury / *Jenis dan tahap kecederaan yang dialami*

* Obligatory / *Wajib*

5. If hospitalisation was due to illness / *Jika kemasukan ke hospital disebabkan penyakit*

a) Nature of illness or symptom? / *Jenis penyakit atau simptom*

b) For how long had you/the Life Assured been having the symptom prior to the first admission? / *Berapa lamakah anda/Diri Yang DiInsuranskan menghadapi symptom sebelum pertama kali dimasukkan ke hospital?*

c) What was the diagnosis? / *Apakah diagnosis ketika itu?*

6. Name and address of doctors who treated you/the Life Assured for this illness or injury / *Nama dan alamat doktor yang merawat anda/Diri Yang DiInsuranskan bagi penyakit atau kecederaan ini* i. ii.	Date of Consultation / *Tarikh rawatan*	Date of Admission (if any) / *Tarikh masuk hospital (jika ada)*

7. Please provide name and address of your/the Life Assured's regular attending doctor other than the above / *Sila nyatakan nama dan alamat doktor yang biasa merawat anda/Diri Yang DiInsuranskan selain daripada yang di atas.*

8. Are you presently insured for Hospitalisation & Surgical benefits under any government law/program, employee benefit, any health benefit scheme or any other insurance policy? If so, please provide details / *Adakah anda, ketika ini dibawah perlindungan insurans faedah Hospital & Pembedahan, dibawah sebarang program/undang-undang kerajaan, kemudahan pekerja, sebarang skim faedah kesihatan atau sebarang polisi insurans lain? Jika ada, sila beri butir*

Name of Company/Program Scheme *Nama Syarikat/Skim Program*	Policy/membership no. *No. polisi/No. keahlian*
i.	
ii.	

Declaration

I hereby declare that the information given in this claim form are true and that I did not suffer from any of the pre-existing conditions at the time of this policy was taken up, I further declare that the current confinement to the hospital is not due to any causes which are stipulated in the Exclusion Clause of the Policy.
I agree that in the event that I make, or have in the past made, any false or untrue statement and/or supressed and/or concealed any materials facts inrespect of my health and condition, the company shall absolutely forfeit my right to compensation and futher reserves the right to recover any amounts paid earlier as a result thereof.

Perisytiharan

Saya dengan ini mengisytiharkan bahawa maklumat yang diberi dalam borang tuntutan ini adalah benar dan bahawanya saya tidak menghidap sebarang penyakit ketika polisi ini dikuatkuasakan. Saya seterusnya mengisytiharkan bahawa kemasukan ke hospital kali ini bukan disebabkan keadaan yang dinyatakan dalam Fasal Pengecualian polisi.
Saya bersetuju bahwanya jika saya membuat atau pernah membuat sebarang kenyataan palsu atau tidak benar dan/atau menghalang dan/atau menyembunyikan sebarang fakta berkaitan dengan kesihatan dengan kesihatan dan keadaan saya, pihak syarikat akan secara mutlak berhak menarik balik hak saya untuk mendapat pampasan dan seterusnya mendapat hak untuk menuntut semula sebarang jumlah yang telah dibayar sebelum ini.

Signature of Life Assured / *Tandatangan Diri Yang DiInsuranskan*

_____

Name / *Nama* :

*D*ate / *Tarikh* :

DECLARATION

I/We further understand and agree that AmMetLife shall have the right to use my/our data and personal information for the purpose of the insurance operational process which might include transfer of data and personal information, within or outside Malaysia, to MetLife Group, AmMetLife's other related companies, subsidiaries and/or its holding companies, outsourcing partners, reinsurers, solicitors, affiliate companies, their outsourcing partners and to any regulatory bodies, including any reporting obligations by AmMetLife Insurance Berhad, its shareholders or its related/affiliated entities under the United States Foreign Account Tax Compliance Act (FATCA).

I/We can withdraw this permission at any time by letting AmMetLife Insurance Berhad know in writing.

I/We understand that I/We have a right to obtain access to and to request correction of any data and personal information held by AmMetLife Insurance Berhad concerning me/us. Such request can be made via a written request to AmMetLife Insurance Berhad.

I/We have read and understood the AmMetLife's Privacy Notice, which is available at AmMetLife's website and branches.

I/We understand that AmMetLife will deduct any withholding required by FATCA.

I/We further understand that AmMetLife Insurance Berhad reserves the right, within its sole discretion, to terminate this arrangement in the event that appropriate documentation of my/our US or non-US status for purposes of FATCA is not timely provided to AmMetLife Insurance Berhad. In particular, in the event that applicable laws or regulations of Malaysia would prohibit withholding on payments to the account or prohibit the reporting of the account, and no waiver of such local law is obtained, AmMetLife reserves the right to close the account.

Claimant's Signature ______________________________

Name* ☐☐

NRIC no.* ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ Old IC/Passport ☐☐☐☐☐☐☐☐

Date ☐☐ / ☐☐ / 2☐☐☐

DIRECT CREDITING (To be completed by claimant)

Please complete the rest of the boxes if more than 1 claimant.

Item	Claimant 1	Claimant 2	Claimant 3	Claimant 4	Claimant 5
Name					
NRIC					
Telephone					
Address					
Occupation					
Country of Birth					
Are you a citizen of the United States of America?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
List other countries of citizenship (if applicable)					
Industry					
Employer's Name					
Employer's Address					

* Obligatory / *Wajib*

Bank Name Please enclose a copy of the first page of your bank passbook (saving account/joint account) or account statement (for current account).					
Account Type (Please tick one)	☐ Savings ☐ Current ☐ Joint	☐ Savings ☐ Current ☐ Joint	☐ Savings ☐ Current ☐ Joint	☐ Savings ☐ Current ☐ Joint	☐ Savings ☐ Current ☐ Joint
Bank Account Number					
Policy No. 1					
Policy No. 2					
Policy No. 3					
Declaration	a. I/We hereby authorise AmMetLife Insurance Berhad to credit claim payment or refund premium of policy referred to herein into my/our bank account as stated above and hereby irrevocably and unconditionally agree to fully indemnify AmMetLife Insurance Berhad and keep AmMetLife Insurance Berhad fully indemnified against all costs, losses, damages or expenses whatsoever that AmMetLife Insurance Berhad may incur or suffer from and against all actions, proceedings, claims and demands taken or made against AmMetLife Insurance Berhad as a result of the credit claim payment or refund premium of policy referred to herein. b. I/We hereby agree to indemnify and keep the Company indemnified against any claims, loss, damage cost and expenses which the Company may suffer or incur due to my authorisation to direct credit payment into the Third Party Account according to the details stated in this form and I/we shall accept full responsibility for this authorisation and shall keep the Company indemnified against all claims, expenses etc arising from this authorisation and I/we hereby give AmMetLife Insurance Berhad a valid discharge from all/any liability for the above said matter				
Signature of Claimant					
Email					
Date					

* Obligatory / *Wajib*