PACIFIC INSURANCE
A member of the Fairfax Group

The Pacific Insurance Berhad (91603-K)
太平保險有限公司
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Website: www.pacificinsurance.com.my

DISCHARGE MEDICAL REPORT CLAIMS

SECTION I - To be completed by the Insured / Claimant (IN BLOCK LETTERS)
SEKSYEN I - Untuk diisi oleh Pihak Diinsuranskan/Pihak Menuntut (DALAM HURUF BESAR)

Name of Insured *Nama Pihak Diinsuranskan*	NRIC No. *No. K/P*	Policy No. *No. Polisi*

Claimant (other than the Insured) *Pihak Menuntut (selain daripada Pihak Diinsuranskan*	Claimant is : *Pihak Menuntut ialah :* ☐ Self/*Diri Sendiri* ☐ Spouse/*Pasangan* ☐ Child/*Anak*	NRIC No. (if applicable) *No. K/P (jika diterima pakai)*

Birth Date *Tarikh Lahir* ☐ (dd) *Tarikh* ☐ (mm) *bulan* ☐ (yy) *Tahun*	Age *Umur*	Sex *Jantina* ☐ Male/*Lelaki* ☐ Female/*Perempuan*	Race *Bangsa*

Religion *Agama*	Marital Status *Status Perkahwinan*	Occupation *Pekerjaan*

Employer *Majikan* Tel. No./*No. Tel.*	Date of Employment *Tarikh Mula Bekerja*	Employer's Address *Alamat Majikan*

Type of Claim
Jenis Tuntutan

☐ Hospitalisation/*Dimasukkan ke hospital* ☐ Outpatient/*Pesakit Luar* ☐ Accident/*Kemalangan*
Circumstances of Accident/*Keadaan Kemalangan*

Are you a GST Registrant?
Adakah anda pendaftar GST? ☐ Yes / Ya ☐ No / Tidak

If yes, please state your GST registration number :
Jika ya, sila nyatakan GST register nombor anda: _____

Details of other insurance policies, Socso, Workmen's Compensation and others:-
Butir-Butir insuran lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain:-

Policy Type *Jenis Polisi*	Insurance Company *Syarikat Insuran*	Policy No. *No. Polisi*

AUTHORISATION TO PHYSICIAN, HOSPITAL, CLINIC OR INSURANCE COMPANY TO RELEASE INFORMATION

MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL, KLINIK ATAU SYARIKAT INSURAN UNTUK MEMBERI MAKLUMAT

I hereby authorise any physician, medical practitioner, hospital, clinic or insurance company by whom or where I have/my ward has been observed or treated,to give full particulars about my/ward's health including my/ward's whole medical history in respect of this hospitalisation/surgery, to the above insurance company.

Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital, klinik atau syarikat insuran yang merawat saya/tanggungan saya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya/tanggungan saya termasuk latarbelakang penuh perubatan saya/tanggungan saya semasa dimasukkan di hospital/menjalani pembedahan kepada syarikat insuran.

.....	.....	.....
Signature of Patient *Tandatangan Pesakit*	Signature of Insured/Claimant *Tandatangan Pihak Diinsuranskan/Pihak Menuntut* (Co. Stamp where applicable/*Cop syarikat dimana perlu)*	Date *Tarikh*

Personal Data Protection Act 2010 ("PDPA") Notification to customers of The Pacific Insurance Berhad ("TPIB")
Under the PDPA, there are various requirements that regulate the processing of your personal data. Please refer to www.pacificinsurance.com.my for details of TPIB PDPA privacy notice.

Akta Perlindungan Data Peribadi 2010 ("APDP") Pemberitahuan kepada pelangan The Pacific Insurance Berhad ("TPIB")
Dibawah APDP, terdapat pelbagai syarat yang mengawal pemprosesan data peribadi. Sila rujuk di www.pacificinsurance.com.my untuk maklumat terperinci notis privasi TPIB APDP.

The Pacific Insurance Berhad (91603-K)

Out-Patient Accidental Treatment Questionnaire

Name of Policyholder/ Patient : ……

Patient Name : ……

NRIC No. : ……

Occupation : ……

Policy No. : ……

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1. a) Cause of Accident : ……

   b) Time of Accident : ……

   c) Date of Accident : ……

   d) State the external and visible injury : ……

   e) State nature of treatment : ……

   f) State the Date and Time of Treatment : ……

2. If surgery was performed, state:

   a) Nature of operation : ……

   b) Date performed : ……

3. Is patient referred for follow up treatment? Yes ☐ No ☐

   If "Yes", state when and for how long? ……

4. Is the present treatment a follow-up of previous accident? Yes ☐ No ☐

   If "Yes", state:

   a) Date of previous accident : ……

   b) Nature of Treatment : ……

Physician / Surgeon Stamp:

_____ _____

Policyholder/ Patient's Signature Physician/ Surgeon's Signature

THE PACIFIC INSURANCE BERHAD (TPIB) -91603K
e-PAYMENT Authorisation Form (Please Tick (4) Accordingly)
****IF YOU HAVE PREVIOUSLY ALREADY SUBMITTED THIS FORM AND THERE IS NO CHANGE IN YOUR BANKING DETAILS, YOU NO LONGER NEED TO SUBMIT THIS FORM.**

Personal Data Protection Act 2010 (PDPA) Notice from The Pacific Insurance Berhad (TPIB) to you. **Under the PDPA, there are various requirements that regulate the processing of your personal data. Please refer to www.pacificinsurance.com.my for details of TPIB privacy notice.**	
☐ New Registration	☐ Update of Details

Particulars *(Please ensure accuracy of details)* :				
☐ Agents	☐ Brokers	☐ Reinsurers	☐ Co-insurers	☐ Adjusters
☐ Repairers	☐ Insured	☐ Beneficiary	☐ Policyholder	☐ Solicitors
☐ Utilities	☐ Service Providers	☐ Financial Institutions	☐ Others (Please specify in next box)	

Name :		
Business/Company Registration No. (Non-Individual)		
NRIC No : (Individual)		
Postal Address :		
Contact Number :	Office:	Mobile:

Important: **PLEASE NOTE THAT EMAIL 2 WILL ONLY BE VALID IF THE TOTAL NUMBER OF CHARACTERS FOR EMAIL 1 AND EMAIL 2 DOES NOT EXCEED FORTY-NINE (49) CHARACTERS. @ - _ (these examples are not exhaustive) ARE EACH CONSIDERED AS 1 CHARACTER.**

Email 1: **(for notification of payment to Payee)**	
Email 2: **(for notification of payment to Servicing Agent)**	

Banking Details *(Please ensure accuracy of details)* :				
Bank Name :				
Bank Account No. :				
Type of Account :	☐ Savings Account	☐ Current Account	☐ Credit Card	☐ Loan Account

Declaration:

1. *I/We hereby authorise TPIB to remit all payments due to me/us to my/our bank account details as indicated above. TPIB will not be liable for any financial loss due to the incorrectness, incompleteness or inaccuracies of the information provided above.*
2. *TPIB may in its absolute discretion elect other modes (such as cheques, cash or bank drafts) other than the e-Payment mode as it deems fit.*
3. *In the event the information provided above has changed, I/We shall inform TPIB of the changes accordingly. I/We understand that I/We need to state our Bank Name and Bank Account Number on each and every occasion a payment is due to us from TPIB.*

I hereby agree to the above terms and conditions and declare that the information provided above are true and correct.

Authorised Signatory and Co. Stamp (if appropriate) Date:

Please return the completed form to the following address or email address:

The Pacific Insurance Berhad (TPIB) – 91603K
40-01, Q Sentral, 2A Jalan Stesen Sentral 2,
Kuala Lumpur Sentral,
50470 Kuala Lumpur.
Email : epayment@pacificinsurance.com.my

For internal Office use only:			
Verified By :		Dept/Branch :	
Client No :		Date :	
Financial Services			
Created By :		Verified By :	