

MEDICAL CLAIM REPORT FORM

SECTION I – To be completed by the Insured / Claimant (IN BLOCK LETTERS) SEKSYEN 1– Untuk diisi oleh Pihak Diinsuranskan/Pihak Menuntut (DALAM HURUF BESAR)			
Name of Insured <i>Nama Pihak Diinsuranskan</i>		NRIC No. <i>No. K/P</i>	Policy No. <i>No. Polisi</i>
Claimant (other than the Insured) <i>Pihak Menuntut (selain daripada Pihak Diinsuranskan)</i>		Claimant is: <i>Pihak Menuntut ialah:</i> <input type="checkbox"/> Self/ <i>Diri Sendiri</i> <input type="checkbox"/> Spouse/ <i>Pasangan</i> <input type="checkbox"/> Child/ <i>Anak</i>	NRIC No. (if applicable) <i>No. K/P (jika diterima pakai)</i>
Birth Date <i>Tarikh Lahir</i> <input type="text"/> (dd) <input type="text"/> (mm) <input type="text"/> (yy) <i>Tarikh Bulan Tahun</i>	Age <i>Umur</i> <input type="text"/>	Sex <i>Jantina</i> <input type="checkbox"/> Male/ <i>Lelaki</i> <input type="checkbox"/> Female/ <i>Perempuan</i>	Race <i>Bangsa</i>
Religion <i>Agama</i>	Marital Status <i>Status Perkahwinan</i>	Occupation <i>Pekerjaan</i>	
Employer Tel. No./No. Tel:	Employee's/Insured Person Address <i>Alamat Pekerja/Yang Diinsurans</i>	Employer's Address <i>Alamat Majikan</i>	
Type of Claim <i>Jenis Tuntutan</i> <input type="checkbox"/> Hospitalisation/ <i>Dimasukkan ke hospital</i> <input type="checkbox"/> Outpatient/ <i>Pesakit Luar</i> <input type="checkbox"/> Accident/ <i>Kemalangan</i> Circumstances of Accident/ <i>Keadaan Kemalangan</i>			
Details of other insurance policies, Socso, Workmen's Compensation and others:- <i>Butir-Butir insuran lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain:-</i>			
Policy Type/ <i>Jenis Polisi</i>		Insurance Company/ <i>Syarikat Insuran</i>	Policy No./ <i>No. Polisi</i>
AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT I hereby authorise any physician, medical practitioner, hospital or clinic 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. <i>Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik 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.</i>			
Signature of Patient <i>Tandatangan Pesakit</i>	Signature of Insured/Claimant <i>Tandatangan Pihak Diinsuranskan/Pihak Menuntut</i>	Date <i>Tarikh</i>	

