KOPERASI CUEPACS ETIQA MUTIARA PLUS
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BORANG TUNTUTAN HOSPITAL

UP : _____

SILA PASTIKAN @ DAPATKAN

SECTION A

1. BAGI TUNTUNTAN **HB** SEBANYAK RM 500.00 ATAU KURANG DAN TEMPOH POLISI LEBIH DARIPADA 2 TAHUN DARI PERMULAAN POLISI SILA KEMUKAkAN **DISCHARGE SUMMARY @ DISCHARGE NOTE** DENGAN PENGESAHAN DOKTOR DAN JUGA T/TGN & COP HOSPITAL.

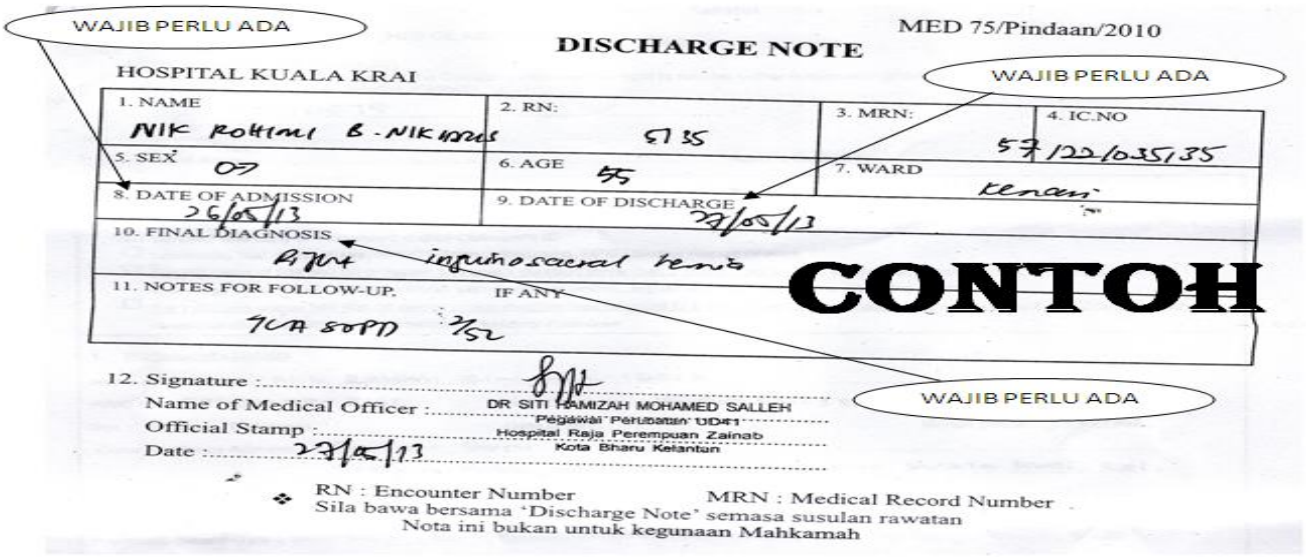
SECTION B

2. BAGI TUNTUTAN **HB** YANG MELEBIHI **RM 500.00** @ TEMPOH POLISI KURANG ATAU SAMA DENGAN **2 TAHUN** DARI PERMULAAN SILA KEMUKAKAN BORANG YANG DILAMPIRKAN **"STATEMENT OF MEDICAL EXAMINER"** DENGAN PENGESAHAN DOKTOR DAN JUGA T/TGN & COP HOSPITAL.

NOTE 1: Sila lampikan juga

-SALINAN IC PESERTA & PENUNTUT
-SALINAN BIL BAYARAN / INVOIS HOSPITAL YANG DI SAHKAN (HOSPITAL SWASTA SAHAJA)
-SALINAN BUKU BANK @ STATEMENT BANK YANG TERTERA NO. AKAUN, NAMA DAN NO IC DIPERLUKAN UNTUK BAYARAN TERUS KE AKAUN AHLI.

****PERMOHONAN HENDAKLAH DIPOSKAN MENGIKUT ALAMAT KAMI DI KOPERASI CUEPACS DAN PERMOHONAN INI TIDAK BOLEH DIFAKSKAN KEPADA KAMI****



ETIQA GROUP CLAIMS SUBMISSION CHECKLIST

GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

Note: We reserve the rights to request further documents if required

Please tick (✓) where applicable;

COMPULSORY FOR ALL CLAIM TYPE SUBMISSION:	
	Etiqa Group Claim Form : Group Major & Hospital Benefits Claims
	Certified copy of Claimant's / Payee's NRIC
	Bank Account Details of Payee and Company Registration Number (If payee is Contract/Policy holder)

DEATH / FUNERAL EXPANSES / KHAIRAT CLAIM	
	Death Statement of Medical Examiner (for policy duration < 5 years)
	Certified copy of Death Certificate
	Proof of relationship between claimant and Participant/Life Assured: Certified copy of ANY one below: - Marriage/ Nikah Certificate if claimant is spouse - Birth Certificate (s) of Child if claimant is child/Children - Birth Certificate (s) of Deceased if claimant is parent (s) - If above is not available, please submit statutory declaration
	Certified copy Sijil Faraid /Court Orders / Letter of Administration (if applicable)
	If death occurred in Overseas: - Confirmation letter from National Registration Department (for death outside of Malaysia) - Death Certificate issued by the country where death occurred (if any) - Certification of death from the hospital where death occurred (if any) - Certification of death from the Malaysian Embassy in the foreign country where death occurred (if an

ACCIDENTAL DEATH CLAIM	
	Death Statement of Medical Examiner
	Certified copy of Death Certificate
	Certified copy of : Police Report , Post Mortem report (if any), Newspaper/Online News cutting (Where applicable)
	Proof of relationship between claimant and Participant/Life Assured : Certified copy of ANY one below: - Marriage/ Nikah Certificate if claimant is spouse - Birth Certificate (s) of Child if claimant is child/Children - Birth Certificate (s) of Deceased if claimant is parent (s) - If above is not available, please submit statutory declaration
	Certified copy : Sijil Faraid /Court Orders / Letter of Administration (Where applicable)

TOTAL & PERMANENT DISABILITY CLAIM	
	Total & Permanent Disability Claim - Statement Of Medical Examiner (Group) Section B (Completion of Section B must be done six months after the diagnosis/disability date)
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports
	Certified copy of Medically Boarded Out letter from employer (if employed)
	Certified copy Other supporting documents (if applicable) etc. SOSCO Pencen Illat medical reports/letters

PERMANENT PARTIAL DISMEMBERMENT/ DISABILITY CLAIM	
	Permanent Partial Dismemberment - Statement Of Medical Examiner Section B
	(Completion of Section B must be done six months after the diagnosis/disability date)
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

ACCIDENT MEDICAL REIMBURSEMENT (AMR) CLAIM	
	Original official receipts and bills
	Discharge note /summary with diagnosis or Medical Report
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports
	Certified copy other supporting documents (if applicable) etc. Police report

HOSPITAL BENEFIT / DAILY HOSPITAL ALLOWANCE CLAIM	
	Original official receipts and bills
	Discharge note /summary with diagnosis or Medical Report
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

TERMINAL ILLNESS BENEFIT CLAIM	
	Critical Illness (Others) – Statement Of Medical Examiner (Group Claim)
	Letter from attending physician stating the current patient's condition, treatment and prognosis.
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

CRITICAL ILLNESS BENEFIT CLAIM

Medical Examiner Form to be completed according to the type of critical illness:

1. Critical Illness (Cancer) – Statement Of Medical Examiner (Group Claim)
2. Critical Illness (Stroke) – Statement Of Medical Examiner (Group Claim)
3. Critical Illness (Renal Failure) – Statement Of Medical Examiner (Group Claim)
4. Critical Illness (Heart) – Statement Of Medical Examiner (Group Claim)
5. Critical Illness (Others) – Statement Of Medical Examiner (Group Claim)

List Of Covered Events And The Required Medical Evidence

Stroke - CT Scan / MRI Report of Brain	**Parkinson's Disease** - All relevant investigation results in support of the diagnosis
Heart Attack / Cardiomyopathy - Cardiac Enzymes Assay results (CK-MB,Troponin T / Troponin I) - ECG tracing - Echocardiogram / Coronary Angiogram report	**Blindness - Permanent and Irreversible** - Visual Acuity Report on both eyes to be done by an ophthalmologist * CMC to be completed by an Ophthalmologist.
Angioplasty and other invasive treatments for coronary artery disease - Coronary Angiogram Report **Coronary Artery By-Pass Surgery** - Coronary Artery By-Pass Surgery Report **Heart Valve Replacement / Surgery** - Heart Valve Surgery Report	**Chronic Lung Disease** - Pulmonary Function Test results - Arterial Blood Gas test results - FEV 1 Test results - Relevant investigation results
Cancer - Histopathology Report (HPE report) - CT Scan / MRI Reports, if available - Bone Marrow Aspiration / Trephine Biopsy Report (Leukemia only) - Blood and laboratory test report	**Motor Neuron Disease** - CT Scan/ MRI report of the Brain and Spine - Electromyography (EMG) test results - All relevant investigation results in support of the diagnosis - Medical Report to be completed by Neurologist
Renal / Kidney Failure / Medullary Cystic Disease - Kidney Dialysis Report / Dialysis Receipts - Kidney/Renal Biopsy Report (if any) - Blood test results	**Multiple Sclerosis** - CT Scan & MRI Report of Brain & Spine - Nerve conduction study / Evoked potential test * Medical Report to be completed by Neurologist
Systemic Lupus Erythematous (SLE) With Lupus Nephritis - Lupus Erythematous (LE) cell blood test results - Anti-DNA Antibodies & Renal biopsy report - Urine FEME results over past 6 months - Renal function tests with eGFR results over past 6 months	**Coma – resulting in permanent neurological deficit with persisting clinical symptoms** - ICU report and supporting documents for being in come > 96 hours - X-ray/CT Scan/ MRI Reports - Medical Report to be completed by Neurologist
Fulminant Viral Hepatitis / End-Stage Liver Failure/ Chronic Liver Disease - CT Scan Report of Liver - Liver Function Test results - Abdominal ultrasound - Hepatitis viral serology test - Any other laboratory or pathology reports	**Muscular Dystrophy** - Lumbar puncture report - Electromyography (EMG) test results - Muscles biopsy - All relevant investigation results in support of the diagnosis - Medical Report to be completed by Neurologist
Brain Surgery - Brain Surgery Report	**Terminal Disease** - All relevant investigation results in support of the diagnosis - Medical Report stating patient not receiving active treatment other than pain relief.
Benign Brain Tumor - CT Scan / MRI Report of Brain - Histopathology Report, if available	**Chronic Aplastic Anemia - resulting in permanent Bone Marrow Failure** - All relevant blood and bone marrow investigation results in support of the diagnosis - Bone Marrow transplantation report
Major Head Trauma - CT Scan / MRI Report of Brain - Surgery report - Police report, if any	**Alzheimer's disease/Severe Dementia / Parkinson's disease** - All relevant investigation in support of the diagnosis - Medical Report to be completed by Neurologist - Physio / Rehabilitation Reports (if Any)
Bacterial Meningitis / Encephalitis - CT Scan / MRI Report of Brain /Spine - CMC to be completed by Consultant Neurologist - Lumbar puncture test report	**Deafness – Permanent and Irreversible** - Audiogram Report (Latest Report) - Pure Tone Audiometry reports (Latest Report)
Major Burns / Third Degree Burns - Total Body Surface Area Burn Assessment Report	**Loss of Speech** - Laryngoscopy report
Paralysis / Paraplegia / Paralysis of limbs - X-ray/CT Scan/ MRI Reports, if available - Medical Report to be completed by Neurologist	**Major Organ / Bone Marrow Transplant** -Transplantation report of heart or lung /liver /kidney /pancreas / bone marrow

Note: Kindly contact our sales/agents or customer service for illness/requirements which is not listed above.

GROUP CLAIMS CLAIMANT STATEMENT FORM

GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

Type of Claims

Note: Please tick (✓) the relevant claims type & refer to Claims Checklist for list of required supporting documents for submission

☐ Hospitalisation Benefit (HB) ☐ Total Permanent Disability ☐ Terminal Illness ☐ Accidental Death

☐ Critical Illness ☐ Partial Permanent Disability ☐ AIR Weekly Indemnity ☐ Death ☐ Khairat

Section A: Details of Person Covered/ Deceased

Contract No				
Name of Contract Holder				
Name of person Covered				
MyKad No. OR Other ID No.				
Contact Details	**Phone**	**Mobile:**	**House:**	**Office:**
	Fax No.		**Email**	
Current Corresponding Address	**Postcode:**	**Town:**	**State:**	
Current Occupation & Job Nature				

Section B: Details of Claimant

Relationship with Person Covered	☐ **Own**	☐ **Spouse**	☐ **Child**	☐ **Parent**
	☐ **Employer**	☐ **Contract Holder**	☐ **Others** *(Please specify:*	*)*
Name				
MyKad No. OR Other ID No.		**Benefit Sum Assured** *(Applicable for Employers only)*	**RM**	
Contact Details	**Phone**	**Mobile:**	**House:**	**Office:**
	Fax No.		**Email**	
Current Corresponding Address	**Postcode:**	**Town:**	**State:**	

Bank Account Details *(Current or Savings Account)*	**Bank Name**	
	Bank Account Holder Name	
	Account Type	☐ **Current** ☐ **Savings**
	Ac count Number	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section C: Details of Claims

Claim Type : Death/ Accidental Death /Funeral Expanses/ Khairat Claim

Date of Death *(dd/mm/yyyy)*		**Last Working Date (If employed)**	
Any Post Mortem Done?	☐ **Yes** *(Please provide copy of the report)* ☐ **No**		

Claim Type : Hospitalisation /Critical Illness/ Terminal illness /AIR Weekly Indemnity Claim

Date of Admission *(dd/mm/yyyy)*		**Date of Discharge** *(dd/mm/yyyy)*	
Admitted Hospital			
Diagnosis			
First Date of Signs & Symptom for the Diagnosis *(dd/mm/yyyy)*		**Medical Certificate (MC) Dates** *(dd/mm/yyyy)*	
Date of Accident *(dd/mm/yyyy)*		**Place of accident**	

Claim Type : Total / Partial Permanent Disability Claim

Date of Admission *(dd/mm/yyyy)*		**Date of Discharge** *(dd/mm/yyyy)*	
Diagnosis			
First Date of Signs & Symptom for the Diagnosis *(dd/mm/yyyy)*		**Medical Certificate (MC) Dates** *(dd/mm/yyyy)*	
Date of MC/ Prolonged Illness Leave	**Start Date** *(dd/mm/yyyy):*	**End Date** *(dd/mm/yyyy):*	
Current Salary Status	☐ **Full Salary**	☐ **Half Salary**	☐ **No Salary**
Last Drawn Monthly Basic Salary	**Paid Date** *(dd/mm/yyyy*	**Salary Amount** **RM**	
Last Working Date *(dd/mm/yyyy)*		**Date of Resignation /Medically Boarded out / Early Retirement (if any)**	

DECLARATION

I do solemnly and sincerely declare that I am the nominee/administrator/beneficiary for the Takaful benefit of the deceased and further declare as follows:-

1. That the foregoing answers and statements on the Deceased are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
2. That any difference, if any, in respect of the details contained in the enclosed supporting document and the information presented to Etiqa Takaful Berhad(Etiqa) in this form refers to the same person. I understand and agree that Etiqa has the sole discretion to reject this application if the information given is false or insufficient.
3. That the original certificate whether or not enclosed therein (if any), due to loss or mutilated, belongs to the deceased.
4. And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish Etiqa Takaful Berhad or its representative any information that may be required concerning my health conditions, for settlement of this claim. I agree that Etiqa Takaful Berhad or its representative may use or disclose any of the information collected or held to third parties such as reinsurers, medical examiner or medical consultant, claims investigator and etc. within or outside Malaysia for the purpose of processing the claim. I agree that a photocopy of this authorization shall be considered as effective and valid as original.
5. I, agree, consent and allow Etiqa Family Takaful Berhad (hereinafter called "Etiqa Takaful") to process my personal data (including sensitive personal data) ('Personal Data') with the intention of processing this Claim Form, in compliance with the provisions of the Personal Data Protection Act 2010.
6. I, understand and agree that any Personal Data collected or held by Etiqa Takaful contained in this Claim Form may be held, used, processed and disclosed by Etiqa Takaful to individuals and/or organizations related to and associated with Etiqa Takaful or any selected third party (within or outside Malaysia, including medical institutions, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this Claim Form and providing subsequent service related to it and to communicate with me for such purposes.
7. I agree that a copy of documents submitted shall be as valid as the original. I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.

Date **Date:**

HOSPITALISATION BENEFIT (HB) - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Participant.
2. Expenses incurred to obtain this report will be borne by the Participant.

Contract No: ……..

1. Name of Patient: ……..
2. NRIC No. : ……..... BC / Old IC No. : ……..Age: ……..
3. Date of Admission: ……..(dd/mm/yyyy) Time : ……...(am/pm)
4. Date of Discharge: ……..(dd/mm/yyyy) Time : ……...(am/pm)
5. Diagnosis: ……..
6. Date of diagnosis: ……....(dd/mm/yyyy)
7. What was the underlying cause and pathology of the above diagnosis?

   ……
8. Did you inform the patient of the diagnosis, if so, when? ……... (dd/mm/yyyy)
9. When you first saw the patient for this illness/ condition …… (dd/mm/yyyy)
10. Have any investigations, tests or procedures been performed? ☐ Yes ☐ No
    i. If so, what were the results?……
    ii. Please furnish a certified true copy of the results
11. Was the patient referred to you by any doctor? ☐ Yes ☐ No
    i. If yes, please indicate the name of doctor and address of the clinic / hospital.

       ……
    ii. Please attach a copy of the referral letter, if any.
12. Who was the doctor who first diagnosed the patient for this illness? Please provide name and address of the doctor

    ……
13. According to the patient:
    i. What were the symptoms complained? ……
    ii. How long had he/she been experiencing these symptoms? ……..
    iii. Did the patient already know or aware he/she has this diagnosis before the first consultation with you? ☐ Yes ☐ No
        a. Since when? …… (dd/mm/yyyy)
    iv. Has the patient previously received any treatment for the above symptom/diagnosis? ☐ Yes ☐ No
        a. If yes, please furnish name and address of the doctor

           ……
        b. Date of last treatment the patient received before first consultation with you: ……(dd/mm/yyyy)
        c. Type of treatments the patient received upon first diagnosed of this illness: .....

           ……
14. Was the condition ☐ Congenital ☐ Hereditary ☐ Alcohol ☐ Nervous
    ☐ AIDS/HIV ☐ Drug Abuse ☐ Cosmetic ☐ Mental ☐ Sexually Transmitted Disease

15. Any surgery/procedure performed? Yes No

i. If yes, please state type of surgery/procedure performed

Type of surgery/procedure	Date (dd/mm/yyyy)	Name of Doctor & Hospital

16. Nature of medical treatment given ……..

17. Any possibility of relapse? ☐ Yes ☐ No

18. Has the patient previously been treated or hospitalized in this hospital or other hospital for any other disease? Yes ☐ No ☐

i. If yes, please state

Date (dd/mm/yyyy)	Diagnosis	Name of Doctor & Hospital

19. If the patient was diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him/ her starting from the first recording done :

Date (dd/mm/yyyy)	Readings of Blood Pressure	Date (dd/mm/yyyy)	Results for Blood Glucose (Fasting)
i. ……	……..	i. ……	……..
ii. ……	……..	ii. ……	……..
iii. ……	……..	iii. ……..	……..

20. For female only - was the patient pregnant at the time of hospitalisation? ☐ Yes ☐ No

i. If so, for how many weeks? ……

ii. Was illness caused directly or indirectly by pregnancy / child birth / caesarian / abortion / miscarriage / infertility and all complications arising therefrom? ☐ Yes ☐ No

If yes, please elaborate : ……

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

……

Signature of Consultant Neurologist

……..

Name of Consultant Neurologist

Professional Qualification: ……..……..

……

.

Clinic / Hospital Stamp:

Date: ……..……

Tel. No:……..