KOPERASI CUEPACS ETIQA MUTIARA PLUS
Wisma Koperasi Cuepacs, No.24-4, Jln 15/48A,
Sentul Raya Boulevard,51000 Kuala Lumpur.
Tel : 03-40440817/03-40429476 Faks : 03-40429475

Pastikan document **disahkan benar lengkap mengikut arahan** sebelum dihantar **agar tidak berlaku penolakan.**

PERKARA: BORANG HILANG UPAYA KEKAL @ SEPARA KEKAL

NOTA : Nama Penuh Peserta merujuk kepada **PESAKIT**

- Sijil penyertaan **TKM0578/TTMW31**. Jika tiada tetapi menjadi ahli **melebihi 60 hari** peserta layak membuat tuntutan. Sila lampirkan surat pengakuan jika tiada sijil.

Dokumen yang perlu dilampirkan:

TYPES OF CLAIMS	DOCUMENTS REQUIRED
Total & Permanent Disability	1) Original certificate/policy contract 2) Total and Permanent Disability Claim form 3) Medical report completed by attending doctor on Insured / Person Covered / Participant's condition after 6 month from the disability date 4) Certified copy of Insured / Person Covered/Participant's IC as evidence of age if proof has not been received before 5) Consent letter for medical report extraction 6) Education level, working experience and detailed job description of last position held 7) Letter of job termination from Insured / Person Covered/Participant 's employer (if employed) 8) Certified copy of clinic/ hospital consultation card 9) Other supporting documents (if applicable)

Jika dokumen sokongan diberikan dalam salinan, dokumen tersebut mestilah disahkan oleh mereka yang dibenarkan oleh Syarikat, Pesuruhjaya Sumpah, 'Notary Public', Peguam, Jaksa Pendamai, Ahli Parlimen, Ketua Balai Polis, Penghulu atau Pegawai Daerah.

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:**

TOTAL & PERMANENT DISABILITY CLAIM - STATEMENT OF MEDICAL EXAMINER (GROUP)

SECTION B

1. Section B is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries sustained or illnesses diagnosed.
2. Completion of Section B must be done **six months** after the diagnosis date.
3. Expenses incurred to obtain this report will be borne by the Participant.

CONTRACT NO:……

Name of Participant:……..……..

NRIC/Birth Cert No/Passport No: ……..

1. Are you the Participant's regular doctor? ☐ Yes ☐ No If yes, since what date ?.....(dd/mm/yyyy)

2. a. Date of **first** consultation for the current condition: ……(dd/mm/yyyy)

   b. Date(s) of subsequent consultation(s)

Date of consultation (dd/mm/yyyy)	Treatment given	Healing progress

   c. Please state the symptoms presented and date symptoms **first** appeared

Symptoms presented at first consultation	Date symptoms first started (dd/mm/yyyy)

   i) What is the source of this information? ☐ Participant ☐ Referring Doctor ☐ Others If "Others", please specify the name of the person and relationship to the Participant.

   ……

   d. Diagnosis:……..

   ……

   ……

   e. Date of **first** diagnosis: ……(dd/mm/yyyy)

   f. Diagnosis was **first** made by (name of doctor):……(dd/mm/yyyy)

   g. Date diagnosis was made known to the Participant:……..(dd/mm/yyyy)

   h. What was the exact information conveyed to the Participant?

   ……...

3. a. Participant's occupation before disability:……

   b. Nature of duties of current occupation:……

   ……

c. How does the Participant's disability prevent him from performing the above listed duties of his/her occupation?

……

……

4.a. Is the condition a result of an accident? ☐ Yes ☐ No

If yes, please state the date of accident:……..(dd/mm/yyyy) ; Time of accident:……..(am/pm)

Describe in detail how the accident happened.

……...

……...

……...

b. Was the accident reported to the police? ☐ Yes ☐ No

If yes, please provide the name of the police division and the police officer-in-charge's name.

……

……

(Please enclose a copy of the police report)

c. Was the Participant under the influence of alcohol/drugs at the time of accident? ☐ Yes ☐ No

If yes, please state the blood alcohol content/drug type and quantity consumed:

……

d. Is the condition self-inflicted? ☐ Yes ☐ No If yes, please provide full details:

……

……

e. Type of treatment including any operations performed and his/her response.

……...

……

5. **Last date of consultation**: …… (dd/mm/yyyy). (Must be within 2 months from the completion of this form)

6. a. Please describe the full nature and severity of the Participant's disabilities.

……

……

b. Is his /her disability progressing, stagnant or recovering?

……

c. Is full recovery expected? ☐ Yes ☐ No If yes, please state approximate date: ……..(dd/mm/yyyy)

If no, please state the extent of recovery and approximate date of the stated extent of recovery

……

……

d. Is the Participant able to perform all the 6 Activities of Daily Living (ADL) without assistance?

Activities of Daily Living	Participant able to perform	
Transfer	Yes	No
Mobility	Yes	No
Continence	Yes	No
Dressing	Yes	No
Bathing/Washing	Yes	No
Eating	Yes	No

e. Is Participant confined to a home/hospital or other institution that provides constant care and medical attention?

☐ Yes ☐ No If yes, since what date:…….. ..(dd/mm/yyyy)

f. Does the patient suffer any loss of use of limbs or/and fingers? ☐ Yes ☐ No

Please state the power of patient's upper and lower limbs

i. Right Upper Limb : …….. Right Lower Limb :……..

ii. Left Upper Limb : …….. Left Lower Limb : ……..

g. Did the patient suffer amputation of limbs or/and fingers? ☐ Yes ☐ No

If yes, please stated level of amputation seen (proximal, middle, distal) …….

h. Did the patient suffer any loss of eyes? ☐ Yes ☐ No

Please give details on Insured's Visual Acuity; (i) Right eye : …… (ii) Left eye : ……..

i. Did the patient suffer any loss of hearing? ☐ Yes ☐ No

If yes, please give details on Insured's hearing, (i) Right ear : ……...db (ii) Left ear : ……db

j. Please give full details with respect to the Participant's mental abilities and cognition.

……

……

k. Is the Participant able to perform all the normal duties of his/her usual occupation? ☐ Yes ☐ No

If yes, when is he/she expected to return to his usual occupation? ……(dd/mm/yyyy)

l. If Participant is unable to return to his/her usual occupation, is he/she able to engage in any other occupation?

☐ Yes ☐ No If yes, what type of occupation can he/she be engaged in?

……

m. When is Participant expected to engage in these occupations? ……..……(dd/mm/yyyy)

7. a. Did the Participant consult other doctors for this condition or its symptoms BEFORE he/she consulted you?

☐ Yes ☐ No If yes, please give name(s) and address(es) of the doctor(s) whom he/she consulted.

Name of Doctor	Name of Clinic/Hospital and Address	Date of First Consultation (dd/mm/yyyy)

b. Is the Participant suffering or has suffered from any other significant illnesses?

☐ Yes ☐ No If yes, please state.

Illness /Diagnosis	Date of First Diagnosis (dd/mm/yyyy)	Name and Address of Attending Doctor

c. i. Is the Participant physically or mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

Please explain:

ii. If yes, when did such disability commence? ……..(dd/mm/yyyy)

d. Is the Participant terminally ill? ☐ Yes ☐ No

8. If the incapacity of the Participant cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future? ☐ Yes ☐ No

If yes, what is the appropriate time period for the Company to re-assess this claim? ……..(dd/mm/yyyy)

9. Please provide us with any other additional information that will enable the Company to assess this claim. Enclose copies of laboratory tests results, if any.

……...

……...

……...

DECLARATION:

I,…….. the undersigned, do hereby declare the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company. Furthermore, I certify that I have personally examined the identity of the above-named Participant and the facts as stated above represent my medical opinion of his/her condition.

…… ……
Signature of the Attending Physician Date (dd/mm/yyyy)

…… ……
Name of the Attending Physician Contact No.

…….. ……
Professional Qualification Official Stamp and Address

Etiqa Family Takaful Berhad (266243D)
(Formerly known as Etiqa Takaful Berhad)
(Licensed under Islamic Financial Services Act 2013 and regulated by Bank Negara Malaysia)
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Ahli Kumpulan Maybank