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 PENYAKIT KRITIKAL
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:

Sila sertakan dokumen-dokumen berikut bersama dengan tuntutan ini (Salinan Disahkan) :

TYPES OF CLAIMS	DOCUMENTS REQUIRED
Critical Illness	1) Borang tuntutan Penyakit Kritikal 2) Salinan Kad Pengenalan yang disahkan 3) Laporan perubatan – Penyakit Kritikal (Strok / Jantung / ESRF / Kanser / Lain-lain) yang dilengkapi oleh doktor 4) Sijil Asal / Salinan Sijil Penyertaan 5) Borang kebenaran untuk maklumat lanjut 6) Lain-lain dokumen yang berkenaan. **(Sila rujuk senarai dokumen sokongan bagi tuntutan penyakit kritikal yang berkenaan)**

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.

****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.

Heart Attack	The death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply and being evidenced by all of the following criteria: (a) A history of typical prolonged chest pain, (b) New electrocardiographic changes resulting from this occurrence, (c) Elevation of the cardiac enzyme, CPK-MB above the generally accepted laboratory levels of normal or troponins recorded at the following levels or higher: - Troponin T > 1.0 ng/ml or equivalent threshold with other Troponin I methods Angina is specifically excluded.
Coronary Artery By-Pass Surgery	Refers to the actual undergoing of open-chest surgery to correct or treat Coronary Artery Disease (CAD) by way of Coronary Artery By-Pass Grafting. Angioplasty and all other intra-arterial, catheter based techniques, keyhole or laser procedures are excluded.
Other Serious Coronary Artery Disease	The narrowing of the lumen of at least three major coronary arteries (not inclusive of their branches) by a minimum of sixty percent (60%) or more as proven by coronary arteriography (non-invasive diagnostic procedures are excluded). Coronary Arteries herein refer to the Circumflex Artery, Right Coronary Artery (RCA), Left Anterior Descending Artery (LAD) and Left Main Stem (a narrowing of sixty percent (60%) or more of the Left Main Stem will be considered as a narrowing of two major arteries). This benefit is payable regardless of whether or not any form of coronary artery surgery has been performed.
Limited Payment (for Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease)	We shall pay ten percent (10%) of the Sum Covered of the Supplementary Contract, up to a maximum of Ringgit Malaysia Fifty Thousand (RM50,000), upon the Covered Member undergoing, for the first time ever, Angioplasty or Other Invasive Treatments For Major Coronary Artery Disease. In the event of a Limited Payment under the Benefit above, the Sum Covered of the Supplementary Contract and the Basic Contract, with respect to the Covered Member, shall be reduced by the amount that is paid.

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:**

CRITICAL ILLNESS (HEART) – STATEMENT OF MEDICAL EXAMINER (GROUP CLAIM)

1. The following named is covered with **ETIQA LIFE INSURANCE BERHAD** against the happening of certain contingents events associated with his/her health. A claim has been submitted in connection with **HEART** and to enable us to assess the claim, we would be obliged if you would complete this Statement of Medical Examiner
2. Any fees chargeable for the completion of this form shall be borne by the claimant.

CONTRACT/ POLICY NO. ……

Name of Participant: ……..

NRIC/Birth Cert No/Passport No: ……

1. Are you the Participant's usual doctor? Yes No

   If yes, since when:……(dd/mm/yyyy)

2. (a) What were the symptoms **first** presented? ……

   (b) How long had the symptoms been present?.....

3. Please state the exact diagnosis:……

4. When this illness was **first** diagnosed?……(dd/mm/yyyy)

5. When was the Participant **first** informed of the diagnosis?……(dd/mm/yyyy)

6. Has the Participant suffered from this illness or any related illnesses previously? Yes No

   If yes, please give details

Dates of consultation(dd/mm/yyyy)	Diagnosis	Treatment given

7. Please state if there is anything in the Participant's family history which would have increased the risk of this illness.

   ……..

8. (a) Was there a history of typical prolonged chest pain? Yes No

   (b) Date of the **first** onset of episode …….. (dd/mm/yyyy)

   (c) Were there any changes in the ECG indicative of a myocardial infarction? Yes No

   (d) Was there a serial elevation of cardiac enzyme (CPK-MB) above normal limit? Yes No

   (e) If yes, please give details

Date of Cardiac Enzyme taken (dd/mm/yyyy)	Cardiac Enzyme/ Biomaker reading	Reading of normal cardiac enzyme

(f) Was coronary arteriography performed? ☐ Yes ☐ No

(g) If Yes, please give details of the results

LOCATION	PERCENTAGE OF NARROWING
Left Main Stem (LMS)	
Left Anterior Descending (LAD)	
Right Coronary Artery (RCA)	
Left Circumflex Artery (LCX)	
Right Circumflex Artery (RCX)	

(f) i. Was coronary bypass surgery performed? ☐ Yes ☐ No

ii. Date of surgery performed. ……(dd/mm/yyyy)

iii. Please state the number and sites of grafts inserted. ……..

(g) i. Was angioplasty (PTCA) performed? ☐ Yes ☐ No

ii. Date angioplasty performed. ……..……(dd/mm/yyyy)

iii. Please state the artery involved: ……..

(I) i. Was heart valve surgery performed? ☐ Yes ☐ No

ii. Date of surgery performed……(dd/mm/yyyy)

iii. Please state the valve involved……..

(j) i. Was aorta surgery performed? ☐ Yes ☐ No

ii. Date of surgery performed……(dd/mm/yyyy)

iii. Please state the aorta involved……..

9. Has the Participant suffered from/has been treated for any other illnesses related to / cause for this Critical Illness? ☐Yes ☐ No

If yes, please give full details (diagnosis & date) ……

……..

10. Did the Participant consult other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐No

If yes, please give details

Date of Consultation (dd/mm/yyyy)	Name and Address of Hospital / Clinic	Diagnosis / Illness

11. Is there anything in the family history which would have increased the risk of hypertension/diabetes/other vascular/disease/ relevant heart disorders, etc. Yes No If yes, please provide details

……

……

12. Any further information which in your opinion will assist us in assessing the claim?

……..

……..

Please furnish copies of all investigation reports including Cardiac Enzyme Assay results (CK-MB), ECG, Troponin T, Coronary Artery Bypass surgery report, Coronary Angiogram report, PTCA report, heart valve surgery report, aorta surgery report and any relevant medical reports that are available.

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief.

…… ……

Signature of Consultant Cardiologist Clinic / Hospital Stamp:

…….... Date: ……

Name of Consultant Cardiologist

Professional Qualification: ……..….. Telephone Number……..……