



**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.

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Dokumen yang perlu dilampirkan:

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

TYPES OF CLAIMS	DOCUMENTS REQUIRED
<b>Critical Illness</b>	<ol style="list-style-type: none"><li>1) Borang tuntutan Penyakit Kritikal</li><li>2) Salinan Kad Pengenalan yang disahkan</li><li>3) Laporan perubatan – Penyakit Kritikal (Strok / Jantung / ESRF / Kanser / Lain-lain) yang dilengkapi oleh doktor</li><li>4) Sijil Asal / Salinan Sijil Penyertaan</li><li>5) Borang kebenaran untuk maklumat lanjut</li><li>6) Lain-lain dokumen yang berkenaan.</li></ol> <p><b>( Sila rujuk senarai dokumen sokongan bagi tuntutan penyakit kritikal yang berkenaan)</b></p>

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: <ul style="list-style-type: none"> <li>- Marriage/ Nikah Certificate if claimant is spouse</li> <li>- Birth Certificate (s) of Child if claimant is child/Children</li> <li>- Birth Certificate (s) of Deceased if claimant is parent (s)</li> <li>- If above is not available, please submit statutory declaration</li> </ul>
	Certified copy Sijil Faraid /Court Orders / Letter of Administration (if applicable)
	If death occurred in Overseas: <ul style="list-style-type: none"> <li>- Confirmation letter from National Registration Department (for death outside of Malaysia)</li> <li>- Death Certificate issued by the country where death occurred (if any)</li> <li>- Certification of death from the hospital where death occurred (if any)</li> <li>- Certification of death from the Malaysian Embassy in the foreign country where death occurred (if any)</li> </ul>

#### 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: <ul style="list-style-type: none"> <li>- Marriage/ Nikah Certificate if claimant is spouse</li> <li>- Birth Certificate (s) of Child if claimant is child/Children</li> <li>- Birth Certificate (s) of Deceased if claimant is parent (s)</li> <li>- If above is not available, please submit statutory declaration</li> </ul>
	Certified copy : Sijil Faraid /Court Orders / Letter of Administration (Where applicable)

<b>TOTAL &amp; PERMANENT DISABILITY CLAIM</b>	
	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

<b>PERMANENT PARTIAL DISMEMBERMENT/ DISABILITY CLAIM</b>	
	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

<b>ACCIDENT MEDICAL REIMBURSEMENT (AMR) CLAIM</b>	
	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

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

<b>TERMINAL ILLNESS BENEFIT CLAIM</b>	
	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

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



**Section C: Details of Claims**

<b>Claim Type : Death/ Accidental Death /Funeral Expenses/ Khairat Claim</b>			
<b>Date of Death</b> (dd/mm/yyyy)		<b>Last Working Date (If employed)</b>	
<b>Any Post Mortem Done?</b>	<input type="checkbox"/> <b>Yes</b> (Please provide copy of the report)	<input type="checkbox"/> <b>No</b>	

<b>Claim Type : Hospitalisation /Critical Illness/ Terminal illness /AIR Weekly Indemnity Claim</b>			
<b>Date of Admission</b> (dd/mm/yyyy)		<b>Date of Discharge</b> (dd/mm/yyyy)	
<b>Admitted Hospital</b>			
<b>Diagnosis</b>			
<b>First Date of Signs &amp; Symptom for the Diagnosis</b> (dd/mm/yyyy)		<b>Medical Certificate (MC) Dates</b> (dd/mm/yyyy)	
<b>Date of Accident</b> (dd/mm/yyyy)		<b>Place of accident</b>	

<b>Claim Type : Total / Partial Permanent Disability Claim</b>			
<b>Date of Admission</b> (dd/mm/yyyy)		<b>Date of Discharge</b> (dd/mm/yyyy)	
<b>Diagnosis</b>			
<b>First Date of Signs &amp; Symptom for the Diagnosis</b> (dd/mm/yyyy)		<b>Medical Certificate (MC) Dates</b> (dd/mm/yyyy)	
<b>Date of MC/ Prolonged Illness Leave</b>	<b>Start Date</b> (dd/mm/yyyy):	<b>End Date</b> (dd/mm/yyyy):	
<b>Current Salary Status</b>	<input type="checkbox"/> <b>Full Salary</b>	<input type="checkbox"/> <b>Half Salary</b>	<input type="checkbox"/> <b>No Salary</b>
<b>Last Drawn Monthly Basic Salary</b>	<b>Paid Date</b> (dd/mm/yyyy)		<b>Salary Amount RM</b>
<b>Last Working Date</b> (dd/mm/yyyy)		<b>Date of Resignation /Medically Boarded out / Early Retirement (if any)</b>	

**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:-

- 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.
- 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.
- That the original certificate whether or not enclosed therein (if any), due to loss or mutilated, belongs to the deceased.
- 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.
- 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.
- 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.
- 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 (RENAL FAILURE) – STATEMENT OF MEDICAL EXAMINER (GROUP CLAIM)**

1. The following named is covered with **ETIQA FAMILY TAKAFUL BERHAD** against the happening of certain contingents events associated with his/her health. A claim has been submitted in connection with **END STAGE RENAL FAILURE** 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 NO:**.....

Name of Participant: .....

NRIC/Birth Cert No/Passport No: .....

1. Are you the Participant’s usual medical attendant?  Yes  No

If yes, since when the Participant has been consulting you? Date : .....(dd/mm/yyyy)

Reason for **first** and subsequent consultations:.....

2. What were the symptoms **first** presented? .....

3. How long had the symptoms been present? .....

4. Please state the exact diagnosis: .....

5. When this illness was **first** diagnosed? Date: ..... (dd/mm/yyyy)

6. When the Participant was **first** informed of the diagnosis? Date : .....(dd/mm/yyyy)

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

No If yes, please give details of consultation, the diagnosis and treatment given :

Dates of consultation	Diagnosis	Treatment given

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

9. Please describe the extent of the kidney failure:-

- a. (i) Has the Participant’s renal disease reach end-stage?  Yes  No

(ii) If yes, please state the date .....(dd/mm/yyyy)

- b. Which kidney (s) is involved?  Right  Left  Both

- c. (i) Is the Participant undergoing regular peritoneal dialysis or haemodialysis?  Yes  No

(ii) If yes, please state the **FIRST** dialysis date.....(dd/mm/yyyy)

(iii) Please state the frequency of required dialysis per week: .....per week

- d. (i) Has renal transplantation been performed?  Yes  No

(ii) If yes, please state the date and name of hospital. Date: ..... Hospital: .....

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

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

11. 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 (dd/mm/yyyy)	Name & address of hospital	Name of doctors	Illness or condition consulted

12. If the Participant 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)

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

.....  
.....

**Please furnish certified true copies of all investigation reports including dialysis report or receipts, blood tests, cytoscopy, pyelograms, ultrasound, biopsy reports, other laboratory reports, surgical procedure, etc. 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: \_\_\_\_\_

Name of Nephrologist: \_\_\_\_\_

Professional Qualification (s): \_\_\_\_\_

Name of Hospital/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone no: \_\_\_\_\_

Official Stamp of Hospital/Clinic

Fax no: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date: \_\_\_\_\_