

**DEATH CLAIM FORM (GROUP CLAIM)**

**SECTION A**

Section A of this form is to be completed by the claimant who is legally entitled to takaful benefit. Every question must be fully answered. The Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

**Contract No** \_\_\_\_\_

Broker/Account Manager's name: \_\_\_\_\_ Broker/ Account Manager's Contact No. : \_\_\_\_\_

**Instruction – Supporting documents required**

- Death claim form
- Death Statement of Medical Examiner
- Certified copy of Participant and Claimant's IC
- Certified copy of Death Certificate
- Certified copy of Burial Certificate
- Original certificate (if any)
- Certified copy of proof of relationship between claimant and participant
- Certified copy Sijil Faraid / Letter of Administration (if applicable)

**Additional requirements on accidental death**

- Detailed Post Mortem report
- Certified copy of Toxicology report, if any
- Certified copy of police report
- Newspaper Cutting, if any

**Additional requirements for death in overseas**

- Confirmation letter from National Registration Department (JPN)
- All relevant documents issued by Foreign Authority must be certified by Malaysia Embassy or Public Notary

**DETAILS OF PARTICIPANT**

Name of Participant in full \_\_\_\_\_

New IC No \_\_\_\_\_ Old IC No. \_\_\_\_\_ Age \_\_\_\_\_

Last Address of Participant \_\_\_\_\_

Name of the Employer of Participant at the time of death \_\_\_\_\_

Address of the Employer \_\_\_\_\_

Date of Employment \_\_\_\_\_ (dd/mm/yyyy) Office Phone No. \_\_\_\_\_

What family has the Participant left?  Spouse  No.of Child \_\_\_\_\_  Parent  Others, please specify \_\_\_\_\_

**DETAILS OF CLAIMANT**

Name of Claimant \_\_\_\_\_

New IC No \_\_\_\_\_ Old IC No. \_\_\_\_\_ Age \_\_\_\_\_

Correspondence Address \_\_\_\_\_  
\_\_\_\_\_

Mobile Phone No. \_\_\_\_\_ E-mail address \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

What is your relationship with the Participant ? \_\_\_\_\_

Please state bank account details in order for us to credit the payment directly into Claimant's bank account.

**Bank :** \_\_\_\_\_ **Bank Branch :** \_\_\_\_\_

**Bank Account Holder Name :** \_\_\_\_\_ **Bank Account no.:** \_\_\_\_\_

**Company Registration no :** \_\_\_\_\_ **(Eg:266243D)**

**The Payment which has been made based on the account details provided by you will be deemed as full payment and we shall be discharged from any existing and future claim and demand in relation to it.**

1 Date of death \_\_\_\_\_ (dd/mm/yyyy) Time \_\_\_\_\_ (am/pm)

2 Cause of death \_\_\_\_\_

3 Place of death \_\_\_\_\_

4 When did Participant **first** complain of or give indication of his / her last illness ? \_\_\_\_\_ (dd/mm/yyyy)

5 When did Participant **first** consult a Physician for his / her last illness? \_\_\_\_\_ (dd/mm/yyyy)

6 Name & address of doctor Participant **first** consulted for his / her last illness \_\_\_\_\_  
\_\_\_\_\_

7 Please state names and address of every physician who attended to the Participant during his / her last illness

| Date of consultation<br>(dd/mm/yyyy) | Date of admission<br>(dd/mm/yyyy) | Date of discharge<br>(dd/mm/yyyy) | Diagnosis | Name of doctor & address of hospitals/clinics |
|--------------------------------------|-----------------------------------|-----------------------------------|-----------|---|
|                                      |                                   |                                   |           |   |
|                                      |                                   |                                   |           |   |
|                                      |                                   |                                   |           |   |

8 State the name and address of Participant's regular doctor \_\_\_\_\_  
\_\_\_\_\_

9 Are there other policies in force on Participant's life taken with other companies?  Yes  No

If yes, please give details:

| Name of Company(s) | Commencement date<br>(dd/mm/yyyy) | Policy no | Type of coverage | Sum assured |
|--------------------|-----------------------------------|-----------|------------------|-------------|
|                    |                                   |           |                  |             |
|                    |                                   |           |                  |             |
|                    |                                   |           |                  |             |

10 Death due to accident

- a. Date of accident : \_\_\_\_\_ (dd/mm/yyyy) Time : \_\_\_\_\_ (am/pm)
- b. Place of accident : \_\_\_\_\_
- c. Why was the Participant at the location ? \_\_\_\_\_
- d. Describe in detail how the Accident happened ? \_\_\_\_\_
- e. Was the accident reported to the police?  Yes  No (If yes, please submit a certified copy of police report)
- f. Was the accident reported in the newspaper?  Yes  No (If yes, please submit a copy)
- g. Was an inquest or post-mortem carried out?  Yes  No (If yes, please submit a certified copy of post mortem report)

**DECLARATION AND AUTHORISATION**

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:-

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 to Etiqa Takaful Berhad or its representative any information that maybe 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 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.

\_\_\_\_\_  
Signature of Claimant

Full name \_\_\_\_\_

Contact No \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

Full Name \_\_\_\_\_

NRIC No \_\_\_\_\_

Contact No \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Authorised Signature of Contract Holder & Company's Stamp

Full name \_\_\_\_\_

Deisgnation: \_\_\_\_\_

Contact No \_\_\_\_\_

Date \_\_\_\_\_

**LETTER OF AUTHORISATION / CONSENT  
TO OBTAIN FURTHER INFORMATION (DEATH CLAIM)**

To Whom It May Concern,

Dear Sir / Madam,

I hereby authorize and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organization, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of the employment, financial, health or medical history of \_\_\_\_\_ (name of Participant) and to provide such information to Etiqa Takaful Berhad or its authorized agents and / or employees.

I expressly waive on behalf of myself and / or as a next-of-kin of the Participant and for his / her estate all provisions of law or professional ethics forbidding the Information or (Providers) from disclosing any such information acquired on the Participant in a professional and / or client capacity and I further release the Information Provider(s) and its agent / staff from any liability whatsoever that may arise, in supplying such information requested by the Etiqa Takaful Berhad.

This authorization / consent is irrevocable and a copy of it will have the same effect and validity as the original.

\_\_\_\_\_  
Signature / Thumb print of Next-of-Kin / Claimant

Name : \_\_\_\_\_

NRIC: \_\_\_\_\_

Old IC: \_\_\_\_\_

Relationship with Participant: \_\_\_\_\_

Contact No: \_\_\_\_\_

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