

## Personal Accident Claim Form

**Important Notice:**

- The participant/policy holder/claimant must give complete and accurate information.
- For your convenience, this claim form is made available at our website: [www.etiqa.com.my](http://www.etiqa.com.my)

### Claim Supporting Documents Checklist

Document Name	Claims Type		
	Medical Expenses/ Hospitalization/ Ambulance Claims	Permanent Disability Claim	Death Claim
1. Admission/ Discharge note of hospital bills	X		
2. Original medical receipts (out-patient)	X		
3. Police report	X	X	
4. Original ambulance fee receipt	X		
5. Copy of MyKad/ Marriage certificate/ Birth certificate	X	X	X
6. Medical specialist report		X	
7. Full photograph of injured person & affected limbs (for amputation only)		X	
8. SOSCO notification		X	X
9. Death certificate			X
10. Burial permit			X
11. Post-mortem report (full)	X		X
12. Letter of administrator			X
13. Others (if any)	X	X	X

### Information on policyholder

Policy no./ Certificate no.:				
Name of policyholder:				
MyKad / Army / Police / Passport no./ Business registration no.:			Occupation:	
Contact details:	Phone no.:	Mobile:	Home:	Office:
	Email:			
Address:				
Postcode:	Town:	State:	Country:	
Bank name:			Account no.:	

### Details of injured person

Name of patient:				
MyKad / Army / Police / Passport no.:				
Contact details:	Phone no.:	Mobile:	Home:	Office:
	Email:			
Address:				
Postcode:	Town:	State:	Country:	
Relationship of patient to policyholder:				

### Details of accident

Date of accident (dd/mm/yyyy):	Time (am/pm):
Location of accident:	
Describe in detail how the accident occurred:	



Describe the injuries sustained:	
Were you in a public transport at the time of accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please specify the type of public transport:
Witness/ witnesses details (if any):	Name: Address: Postcode:                      Town:                      State:                      Country: Mobile:                      Home:                      Office:
Doctor who attended the injured person:	Name: Address of hospital/ clinic: Postcode:                      Town:                      State:                      Country: Mobile:                      Home:                      Office:
Family doctor (if any):	Name: Address of hospital/ clinic: Postcode:                      Town:                      State:                      Country: Mobile:                      Home:                      Office:

### Declarations

I/We declare that the above statements and particulars are correct and complete in every aspect and I/We have not concealed, misrepresented or misstated any material fact in relation to this claim.

I/We hereby authorize any hospital or clinic doctor or any other person who has attended or examined me to disclose to Etiqa Insurance Berhad/ Etiqa Takaful Berhad full particulars in respect to any illness and injury, medical history, consultation, prescription or treatment. A duplicate of this authorization shall be considered as effective and valid as the original.

Signature of patient  
Date

Signature of policyholder  
Date

Note: (a) For death claim, next-of-kin is to sign.  
(b) For Senior PA policy, signature of the injured person is sufficient.

### Medical certificate

**To be completed by attending doctor (any fees incurred for the completion of this medical certificate shall be borne by the patient)**

Name of patient:		
MyKad / Army / Police / Passport no.:		
Brief description of the injuries sustained:		
Were there any external and visible injuries or wounds as a result of this accident?  <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the extent of injuries including site and other characteristics / features as seen by you:	If no, please describe any other evidence that is consistent with the accident as claimed by the patient:
Are the injuries sustained consistent with the nature of the accident?  <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, was it contributed by other degenerative illness/ disease? (Please include details)  Period the patient has been suffering from the illness/ disease:	
Are the injuries sustained contributed by osteoporosis, hernia bone disease, pathological fracture, physical deformity, mental or nervous disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, is it:	
	<input type="checkbox"/> Pre-existing	<input type="checkbox"/> 1 <sup>st</sup> time detected
Please provide details:		
How was the patient treated?  <input type="checkbox"/> Out-patient <input type="checkbox"/> In-patient (hospitalized)	If out-patient, please provide details:	
	Name of doctor:	
Name of hospital/ clinic:		
Did the patient use the service of an ambulance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this a follow-up treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient recommended for nursing care at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient recommended to use any orthopedic equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you think the patient was intoxicated with alcohol or drugs at the time of accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Details of hospitalization

Name of hospital/ clinic:			
Period of hospitalization:	Normal ward:	Date of admission (dd/mm/yyyy):	Time of admission (am/pm):
		Date of discharge (dd/mm/yyyy):	Time of discharge (am/pm):
	Intensive care unit:	Date of admission (dd/mm/yyyy):	Time of admission (am/pm):
		Date of discharge (dd/mm/yyyy):	Time of discharge (am/pm):
Was surgery performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was a biopsy done? <i>(for cancer patient only)</i>	<input type="checkbox"/> Yes, please enclose a copy of histopathology report should the cells/ tissues are confirmed to be cancerous.	<input type="checkbox"/> No	
Date of surgery (dd/mm/yyyy):		Name of surgeon:	

### Details of temporary disability

Name of hospital/ clinic:		
Name of doctor:		
Period of temporary total disability (Medical Leave) issued:	From:	To:
Period of temporary partial disability (Light Duty) issued:	From:	To:

### Details of permanent disability

Comment on disability of patient: (Claim documents must be submitted within 1 year from the date of the accident)

No disability
  Possible disability in future
  Disability is apparent

If disability is apparent, please confirm the percentage (%) of disability sustained if patient had reached Max Medical Improvement (MMI):

### Details of death

Date of death (dd/mm/yyyy):		
Death was due to:	<input type="checkbox"/> Accident	<input type="checkbox"/> Illness
Actual cause of death:		
Was it contributed partly by any degenerative illness?		
Was any blood specimen taken for drug/ alcohol test (toxicology)?		

### Declarations

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.

Signature of Attending Physician

Clinic/ Hospital Stamp  
Date:

Name of Attending Physician & Qualification

Tel. No: