CUEPACS ETIQA MUTIARA PLUS

Level 3 Bangunan PSM no 17B Jalan Bangsar 59200 Kuala Lumpur
Tel : 0322836364/6361 Faks : 0322836272 H/p : 017-6340518

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 **TKM 0679 / TTMW4**. 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 BANGSAR 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.

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 (OTHERS) – 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 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:……..

Claims condition suffered (Please tick (√) where applicable)

☐ End Stage Liver Failure	☐ Benign Brain Tumour	☐ Paralysis/Paraplegia
☐ Fulminant Viral Hepatitis	☐ Blindness/ Total loss of sight	☐ Loss of Hearing/Deafness
☐ Coma	☐ Major Burns	☐ Multiple Sclerosis
☐ Occupationally Acquired HIV Infection	☐ End Stage Lung Disease	☐ Medullary Cystic Disease
☐ Encephalitis	☐ Loss of Speech	☐ Bacterial Meningitis
☐ Brain Surgery	☐ Terminal Illness	☐ Parkinson's Disease
☐ Major Head Trauma	☐ Chronic Aplastic Anaemia	☐ Primary Pulmonary Arterial Hypertension
☐ Motor Neuron Disease	☐ Muscular Dystrophy	☐ Major Organ/Bone Marrow Transplant
☐ Systemic Lupus Erythematosus with lupus Nephritis	☐ Alzheimer's Disease/Irreversible Organic Degenerative Brain Disorder	☐ Poliomyelitis

Name of Participant: …….

NRIC/Birth Cert No/Passport No: ……

1. Are you the Participant's usual Medical Attendant? ☐ Yes ☐ No If yes, since when……..……(dd/mm/yyyy)

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

2. (a) Please state the exact diagnosis: ……..…….

   (b) What was the underlying cause of the diagnosis? …….

   (c) Date when **first** diagnosis made: ……..(dd/mm/yyyy)

   (d) Diagnosis was made by (name of doctor) ……

   (e) Please provide details of the history of symptoms:…….

   (f) How long had symptoms been present? ……..

   (g) Date when Participant **first** became aware of the symptoms……(dd/mm/yyyy)

   (h) Date when Participant **first** consulted you for the symptoms……..(dd/mm/yyyy)

   (i) 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	Reasons for consultation

   (j) Is there anything in the Participant's family history which would have increased the risk of this illness?

   ……

   ……

3. (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.

……

……

4. (a) Please provide full address of any hospitals / Clinics to which the Participant has been referred together with the names of the consultants attended.

Date (dd/mm/yyyy)	Hospital / Clinic	Address	Name of consultant

(b) What tests were performed to confirm the diagnosis?

……

(Please enclose certified true copy of all test reports)

(c) Please describe the nature of treatment and medication prescribed

……

……

(d) What is the current condition of the Participant and what is the prognosis?

……..

(e) Has the patient suffered or been treated for any chronic sickness or other than this critical illness? If yes, please give full details

Date(dd/mm/yyyy)	Name & address of doctor	Reason for consultation	Diagnosis

5. (a) Last date of consultation: ……..(dd/mm/yyyy)

(b) Did the Participant suffer any loss of use of limbs? ☐ Yes ☐ No

Please state the power of patient's upper and lower limbs as at last consultation date

Limb	Power
Right upper limb	
Left upper limb	
Right lower limb	
Left lower limb	

(c) Did the Participant suffer any loss of eyes? ☐ Yes ☐ No

Please give details on Participant's Visual Acuity as at last consultation; (i) Right eye : …….. (ii) Left eye : ……..

(d) Did the Participant suffer any loss of hearing? ☐ Yes ☐ No

Please give details on Participant's hearing as at last consultation; (i) Right ear : ……db (ii) Left ear : ……db

(e) Is the Participant able to perform all the 6 Activities of Daily Living (ADL) without assistance as at last consultation?

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

6. Any further information which in your opinion will assist us in assessing this claim

……...

Please attach certified true copies all laboratory test reports e.g. liver function test, CT/MRI report of brain/liver/spine, visual acuity report, medical evidence for usage of life support, audiometry test, sound threshold test result, total body surface assessment, surgery report, biopsy, blood test, pulmonary function test, FEV 1 test and any relevant hospital 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 and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : _____

Name of Doctor : _____ Qualification : _____

Telephone No. :_____Fax No. :_____Date :_____(dd/mm/yyyy)

Official Stamp of Doctor : Name and Address of Clinic / Hospital Official Stamp

_____ _____

Etiqa Family Takaful Berhad (266243D)
(Formerly known as Etiqa Takaful Berhad)
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