

TOTAL & PERMANENT DISABILITY CLAIM FORM

For Maybank use only. Compulsory to fill up for RTA / RTT claims or application will be incomplete.

| | | |
|-----------------------------|--|--|
| Loan Type: | <input type="checkbox"/> ASB | <input type="checkbox"/> Mortgage / Others |
| Loan Status: | <input type="checkbox"/> Full Settlement | <input type="checkbox"/> Outstanding |
| Full Settlement Date: _____ | | |

SECTION A

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: _____

Agent's name & code: _____ Agent's Contact No.: _____

Instruction – Supporting documents required

- ☐ Total and Permanent Disability Claim form
- ☐ Total & Permanent Disability Statement of Medical Examiner (latest condition after 6 months from the first date of disability occurred)
- ☐ Certified copy of Participant and/or Claimant's IC
- ☐ Medical Boarded Out / Employment Termination Letter from Participant's employer (if employed)
- ☐ Certified copy of clinic / hospital consultation card
- ☐ PERKESO / SOCSO report and Approval Letter (if any)
- ☐ Other supporting documents (if applicable)

Person Covered's Details

Name of Person Covered: _____

New IC No.: _____ Old IC No.: _____ Age: _____

Correspondence Address: _____

Mobile Phone No.: _____ E-mail address: _____

House Phone No.: _____ Office Phone No.: _____ Fax No.: _____

Highest education level: ☐ Primary ☐ Secondary ☐ Diploma ☐ Bachelor Degree ☐ Master ☐ PhD

Please list the jobs held in the past 3 years (Begin with the most recent jobs):

| Dates (dd/mm/yyyy) (From – To) | Job Title & Employer's Address | Exact Duties | Average Monthly Income (RM) |
|-----------------------------------|--------------------------------|--------------|--------------------------------|
| | | | |
| | | | |
| | | | |

Claimant's Details (If other than Person Covered)

Name of Participant: _____

New IC No.: _____ Old IC No.: _____ Age: _____

Correspondence Address: _____

Mobile Phone No.: _____ E-mail address: _____

House Phone No.: _____ Office Phone No.: _____ Fax No.: _____

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

Account Bank: Branch: Account No.:

Account Holder's Name:

NRIC (as per bank account):

Type of account : ☐ Individual ☐ Joint

Company Registration No. (If payment to company):

Employment Details Prior to Disability

1. Type of Employment: ☐ Full-time ☐ Part-time ☐ Self-employed (details:)
☐ Unemployed **if unemployed, please continue to "Details of Disability" section.*

2. Name of Employer prior to onset of disability:

3. Address of Employer prior to onset of disability:

..... Office Phone No.:

4. Period of Employment: From: (dd/mm/yyyy) To: (dd/mm/yyyy)

5. Job Title / Position prior to onset of disability:

6. Please indicate your working environment: ☐ Factory ☐ Office ☐ Outdoors ☐ Others (details:)

7. Type of industry:

8. Please indicate your exact duties / activities and time allocation for each activity prior to the onset of disability:

| Type of Activities / Duties (Administrative, standing for long hours, driving, labour work, operating machineries etc.) | Time Allocated For Each Activity (hours / day) |
|--|---|
| | |
| | |
| | |
| | |
| | |

9. Are you in management or supervisory capacity? ☐ Yes ☐ No

If yes, please provide details:
.....

10. Do you operate any machine or special equipment? ☐ Yes ☐ No

If yes, please indicate the type of machine / equipment used
.....

11. What is the qualification needed for the job?
.....

12. Does your job requires any special skills / knowledge? ☐ Yes ☐ No

If yes, please provide details:
.....

13. What is your normal working hours and days?
.....

14. Are you required to work on shift, weekends, public holidays or on-call basis? ☐ Yes ☐ No

If yes, please provide details:
.....

15. Does your job requires travelling? ☐ Yes ☐ No

If yes, please state how many KM/week: KM/week OR ☐ Others (details:)

16. Please state your last working date: (dd/mm/yyyy)

17. Have you been advised to change your job scope to suit your disability? ☐ Yes ☐ No
If yes, please give details
Please provide the effective date of your new job scope: (dd/mm/yyyy)
18. What aspects of your disability prevent you from performing the following:
a) Your own occupation
Details
b) Any other occupation
Details
19. Please state the date you are expected to resume your work and daily activities: (dd/mm/yyyy)
20. Are you currently engaged in duties of any occupation or endeavor for wages, profit, compensation or volunteerism?
☐ Yes ☐ No
If yes, please provide details:
21. Do you intend to seek another employment? ☐ Yes ☐ No
If yes, please state the nature of work
.....
If no, please provide reason
.....
22. Please provide your medical boarded out date / employment termination date:(dd/mm/yyyy)

Details of Disability

1. Condition/Disability due to Accident
(a) Please provide details of the accident:
Date: (dd/mm/yyyy) Time: (AM / PM) Place:
(b) Please describe what were you doing at the time of Accident?
.....
(c) Please describe in detail how did the Accident happened
.....
2. Condition/Disability due to Illness
(a) Please fully describe the symptoms for which you consulted a medical practitioner.
.....
(b) When did you **first** had the symptoms? (dd/mm/yyyy)
(c) When did you **first** consulted a doctor for this condition? (dd/mm/yyyy)
(d) Please provide the name & address of the doctor you **first** consulted for this condition:
Name:
Address of Hospital / Clinic:
(e) What was the diagnosis?
(f) What treatments are you currently receiving?
.....
(g) Have you previously suffered from, or received treatment for a similar or related illness? ☐ Yes ☐ No
If yes, please provide details:

| Date of consultation (dd/mm/yyyy) | Name of doctor | Hospitals / Clinics |
|--------------------------------------|----------------|---------------------|
| | | |
| | | |
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| | | |

- (h) Please provide the name and address of your regular treating doctor.

| | | |
|----------------------------------|---|--|
| | Common illnesses (i.e fever, flu, cough) | Related to the above disability |
| Doctor's Name | | |
| Clinic / Hospital Address | | |

(i) Are you receiving any income from other sources? ☐ Yes ☐ No
If yes, please provide details:

(j) Please indicate whether you are left or right handed: ☐ Right handed ☐ Left handed

Are there other policies in force on your life taken with other insurers / takaful operators? ☐ Yes ☐ No
If yes, please provide details:

| Name of Company(s) | Policy / Certificate Date (dd/mm/yyyy) | Policy / Certificate No | Plan / Type of Coverage | Amount of Benefit (RM) |
|--------------------|--|-------------------------|-------------------------|------------------------|
| | | | | |
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| | | | | |

CLAIMANT'S DECLARATION & AUTHORISATION

I hereby declare that the foregoing answers and statements in this claim form are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.

And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish to Etiqa Family Takaful Berhad (Formerly known as Etiqa Takaful Berhad) or its representative any information that maybe required concerning my health conditions, for settlement of this claim. I agree that Etiqa Family 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.

.....
Signature / Thumb print of Person Covered

Name:
Date: (dd/mm/yyyy)

.....
Signature / Thumb print of Claimant (if other than Person Covered)

Name:
Date: (dd/mm/yyyy)
Contact No.:
Designation & official stamp is required for Company or Bank:

.....
Signature of Witness

Name:
NRIC:
Date: (dd/mm/yyyy)
Contact No.:

LETTER OF AUTHORISATION / CONSENT

To Obtain Further Medical information

To Whom It May Concern,

Name of Person Covered:

NRIC No.: (New) (Old)

Contract No.:

I,, NRIC No. hereby authorize and give my consent to any medical practitioner, physician, surgeon, nurse, medical staff, clinic, hospital, medical centre, insurance company or organization or individual concerned ("the information provider") that may have any record or knowledge of health or medical history of the above stated ("Person Covered") and to provide such information to Etiqa Family Takaful Berhad (Formerly known as Etiqa Takaful Berhad) and its authorized service provider and/or its employees in order to process my Takaful claim.

I, agree, consent and allow Etiqa Family Takaful Berhad (hereinafter called "Etiqa Family 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 expressly waived all provisions of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on myself 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 Company.

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

.....
Signature / Thumb print of Person Covered / Participant (if Person Covered is a minor)

Name:

NRIC:

Old I/C:

Birth Cert No (if minor):

Relationship with Person Covered:

Contact No.:

Date: (dd/mm/yyyy)

WHY YOU SHOULD CHOOSE TO RECEIVE PAYMENTS VIA DIRECT DEPOSIT INTO A BANK ACCOUNT (E-PAYMENT / AUTO-CREDIT)?

| No | Question | Answer |
|-----|--|--|
| 1 | Why should I choose to receive funds via e-payment / auto-credit? | <ul style="list-style-type: none"> ✓ Faster: funds are available once the payment has been processed by the bank. ✓ Convenient: removes the need to travel and deposit the cheque at the bank as payments are credited directly into your bank account. ✓ Safer: misplaced, lost, fraud or expired cheques will no longer be an issue. ✓ Environmental friendly: printing, posting and banking in of the cheque will no longer require. |
| 2 | Will there be any registration fee? | No, you can enjoy the service free of charges. |
| 3 | What do I have to do to receive funds via e-payment / auto-credit? | <p>You must provide your bank's saving / current account number together with the bank's name in the proposal/claim/benefit/surrender form during the application.</p> <p>Alternatively, you can also provide your bank saving / current account no with the bank's name, latest address, mobile phone no and email address for future Benefit payment via submission of 'Request For Change Form'.</p> <p>Note: The completed form and necessary documents must be submitted together with the required supporting documents to the nearest Etiqa Branch.</p> |
| 4 | What are the required supporting documents? | <p>The following documents are required for verification :</p> <ul style="list-style-type: none"> ✓ A copy of your IC or passport, ;& ✓ A copy of the bank statement / bank account passbook / details of your account printed from your bank's website. |
| 5 | Is there any restriction on the type of bank account that can be assigned for e-payment / auto-credit? | <p>You can provide any of your existing active saving / current account held under your name or in the case of a joint account that has your name as one of the accountholders. The saving or current account must be maintained with one of the financial institutions offering MEPS Inter-Bank GIRO (IBG) service. You may refer to the following website for current list of IBG members</p> <p>http://www.meps.com.my/faq/interbank-giro.</p> |
| 6 | Can I change my bank account information? | Yes, you are allowed to change your bank account details by submitting the Request For Change form with the required supporting documents substantiating your request to Etiqa. No cost will be charged for this purpose. |
| 7. | When will the funds be credited to my bank account? | Payment will be made electronically into your bank account by Etiqa within 5 working days once your payment has been approved. |
| 8. | Will I be notified once the takaful operator has made the payment? | Yes, a notification letter will be sent to you once your payment has been approved. You are encouraged to provide your email address/mobile phone number as Etiqa is currently developing the electronic notification via email / SMS. |
| 9. | How will my bank account information be used and will it remain confidential? | <p>Your bank account details and other related information:</p> <ul style="list-style-type: none"> ✓ Will be used solely for the purpose of enabling payments to be credited directly into your bank saving / current account; and ✓ Is protected under the Islamic Financial Services Act 2013 that strictly prohibits the disclosure of such information to any person unless customer or his personal representative has given written permission. |
| 10 | What will happen to funds that cannot be credited into my bank account? | If funds cannot be credited into your bank account due to for example, incorrect bank account number, closed or inactive bank account, I/C no unmatched, the cheque will be issued and posted to you. However, this may lead to unnecessary delay to the payment process. To avoid this issue, please ensure that your bank account is correct and active upon providing such information to Etiqa. |
| 11. | Do I need to provide bank account information separately for each of my certificate if I have more than one certificate? | If you want all your payments to be paid to the same bank account, you need to indicate so to Etiqa at the point of submitting your form. |