CRITICAL ILLNESS CLAIM FORM

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

- ☐ Critical Illness claim form
- ☐ Certified copy of Participant and/or Claimant's IC
- ☐ Critical Illness - Statement of Medical Examiner (Stroke / Heart / End Stage Renal failure / Cancer / Others)
- ☐ Relevant diagnostic test results or report to support the diagnosis (Please refer page 5-6)
- ☐ Original certificate/policy contract
- ☐ Other supporting document (if applicable)

Name of Participant _____

New IC No _____ Old IC No. _____ Age _____

Correspondence Address _____

_____

Mobile Phone No. _____ E-mail address _____

Phone No. _____ Fax No. _____

Name of the Employer _____

Address of the Employer _____

_____ Office Phone No. _____

Date of Employment _____ (dd/mm/yyyy)

1 Describe fully the symptoms for which you consulted a medical practitioner.

_____

2 Date symptoms **first** commenced _____ (dd/mm/yyyy)

3 Date you **first** consulted doctor for this condition _____ (dd/mm/yyyy)

4 Name & address of doctor you **first** consulted for this condition _____

_____

5 What was the diagnosis? _____

6 What treatment are you currently receiving? _____

7 Have you previously sufferred from, or received treatment for a similar or related illness? ☐ Yes ☐ No

If yes, please give full details _____

8 State the name and address of your regular doctor _____

_____

9 Please give details of any other doctors you have consulted in connection with this or other conditions.

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

10 Are there other policies in force on your life taken with other companies ? ☐ Yes ☐ No

If yes, please give details:

Name of Company(s)	Commencement date (dd/mm/yyyy)	Policy no	Type of coverage	Sum assured

11 Please state your (the Claimant) bank account details in order for us to credit the payment directly into your bank account.

Bank : _____ Account no: _____

12 Goods and Service Tax (GST) Registration Details of Contract Holder

Name of Contract Holder _____

New IC No _____ Old IC No. _____

Mobile Phone No. _____ Office Phone No. _____

House Phone No. _____ Fax No. _____

Email Address _____

a) Contract Holder was GST registered during inception / commencement of the insurance benefit(s) currently claiming?

☐ Yes ☐ No

b) If the above answer is 'Yes', please complete the following details :

i) GST Registration Number : _____

ii) Business Registration Number (if GST registered under Company) : _____

iii) GST Taxpayer Name : _____

iv) Purpose of this takaful benefit : ☐ Business Related ☐ Non-business related

v) GST Registration Date : _____ GST De-Registered Date : _____

Note: Etiqa Family Takaful Berhad (Formerly known as Etiqa Takaful Berhad) shall rely on the above information provided by you for tax credit purposes provided under the Goods and Services Tax Act 2014. Etiqa Family Takaful Berhad shall not be liable for any liability, fine, charge or penalty as a result of relying the incorrect information. Should any action be taken against Etiqa Family Takaful Berhad and/or penalties be imposed on Etiqa Family Takaful Berhad by any tax authority for relying on the same. Etiqa Family Takaful Berhad reserves its right to be idemnified by you to the fullest extent permitted by law any liability arising from your incorect advice shall be payable by you.

DECLARATION

I/We hereby declare that the foregoing answers and statements are complete and true to the best of my/our knowledge and belief, and that I/we have withheld no material facts from the Company.

Signature / Thumb print of Participant

Name _____

Date _____ (dd/mm/yyyy)

Signature / Thumb print of Claimant (if other than Participant)

Date _____

Full name _____

Contact No _____

Designation & Official stamp is required for Company or Bank:

Signature of Witness

Date _____

Full Name _____

NRIC No _____

Contact No _____

LETTER OF AUTHORISATION / CONSENT

TO OBTAIN FURTHER INFORMATION (LIVING TAKAFUL CLAIM)

To Whom It May Concern,

Contract No _____

Dear Sir / Madam,

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

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 rise, in supplying such information requested by the Company.

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

_____

Signature / Thumb print of Participant

Name _____

NRIC _____

Old IC _____

Birth Cert No. (if minor) _____

Tel No. _____

Date _____ (dd/mm/yyyy)

_____

Signature of Contract holder (If Participant is a minor)

Name _____

NRIC _____

Old IC _____

Tel No _____

Date _____ (dd/mm/yyyy)

Etiqa Family Takaful Berhad (266243D)
(Formerly known as Etiqa Takaful Berhad)
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Ahli Kumpulan Maybank

Additional Requirements For Critical Illness Claim

Critical Illness	Additional Required Medical Evidence
Stroke	1. CT Scan / MRI of Brain report 2. Doctor's Statement to be completed by Consultant Neurologist (for current condition at least 6 months after the stroke)
Heart Attack	1. Cardiac Enzymes Assay results (CK-MB) 2. Electrocardiography report (ECG) 3. Tropinin T result, if any 4. Doctor's Statement to be completed by Consultant Cardiologist
End Stage Kidney Failure	1. Dialysis appointment card / receipts 2. Blood test results 3. Doctor's Statement to be completed by Consultant Nephrologist
Cancer	1. Histopathology/biopsy report (where applicable) 2. Bone Marrow Aspiration report (leukemia) 3. CT Scan / MRI report (where applicable)
Coronary Artery By-Pass Surgery	1. Coronary Artery By-Pass Surgery Report
End Stage Liver Failure	1. Liver Function Test 2. CT Scan of Liver 3. All laboratory, pathology, hepatitis screening, ultrasound & histology report
Fulminant Viral Hepatitis	1. CT Scan report of Liver 2. Liver Function Test results 3. Any other laboratory or pathology reports
Coma	1. Medical receipt for the usage of life support (Oxygen) 2. Doctor's Statement to be completed by Consultant Neurologist
Benign Brain Tumour	1. CT Scan / MRI of Brain report 2. Histopathology/biopsy report
Paralysis / Paraplegia	1. X-ray / CT Scan / MRI report, if available 2. Doctor's Statement to be completed by Consultant Neurologist
Blindness / Total Loss of Sight	1. Visual Acuity report on both eyes to be done by an ophthalmologist 2. Doctor's Statement to be completed by an Ophthalmologist
Deafness / Total Loss of Hearing	1. Audiometry test and Sound Threshold test results
Major Burns	1. Total Body Surface Assessment report
End Stage Lung Disease	1. Pulmonary Function test 2. FEV 1 test 3. Relevant medical reports
Encephalitis	1. CT Scan / MRI of Brain 2. Doctor's Statement to be completed by Consultant Neurologist
Major Organ / Bone Marrow Transplant	1. Surgery report
Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease	1. Coronary Angiogram report 2. Surgery report
Loss of Speech	1. Medical evidence from ENT specialist to confirm illness or injury to vocal cords 2. Doctor's Statement to be completed by speech pathologist / therapist
Brain Surgery	1. Brain Surgery report
Heart Valve Surgery	1. Heart Valve Surgery report

Critical Illness	Additional Required Medical Evidence
Terminal Illness	1. All relevant investigation result in support of the diagnosis
Bacterial Meningitis	1. CT Scan / MRI of Brain & Spine
Major Head Trauma	1. Detailed medical assessment from attending doctor 2. CT Scan / MRI of Brain 3. Police report, if any
Other Serious Coronary Artery Disease	1. Coronary Angiogram report
Chronic Aplastic Anaemia	1. Bone Marrow Aspiration 2. Blood test report
Motor Neuron Disease	1. All investigation reports
Parkinson's Disease	1. Detailed medical assessment including Activities of Daily Living from Consultant Neurologist
Muscular Dystrophy	1. Diagnostic test result 2. Doctor's Statement to be completed by Consultant Neurologist
Surgery to Aorta	1. Aorta Surgery report
Multiple Sclerosis	1. Ophthalmologist's report 2. CT Scan & MRI report of Brain & Spine 3. Doctor's Statement to be completed by Consultant Neurologist
Medullary Cystic Disease	1. Abdominal Ultrasound or Abdominal CT Scan 2. Renal biopsy report 3. Urine Specific Gravity Test 4. Blood test result 5. All clinical and laboratory investigation report
Severe Cardiomyopathy	1. Chest X-ray 2. Echocardiogram report
SLE with Lupus Nephritis	1. Urine test results 2. Blood test results 3. Kidney biopsy report
Primary Pulmonary Arterial Hypertension	1. All clinical and laboratory investigation including cardiac catheterization
Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders	1. Diagnostic test results