هوڠ ليوڠ م.س.أج. تكافل
HongLeong MSIG Takaful

CF06300001

Claim No. : _____ Submission Branch : _____

Agent Who Submits the Claim : _____ Date Customer Informed Agent of the Claim : _____

HOSPITALISATION BENEFIT / HOSPITAL INCOME / HOSPITAL & SURGICAL / ACCIDENTAL MEDICAL REIMBURSEMENT/ WEEKLY INDEMNITY APPLICATION FORM

This form is to be completed by the person entitled to the certificate monies.

Part I – Particulars of Certificate and Person Covered (Event Person)

1. Takaful Certificate No.:	2. Name :
3. New IC No./Passport No.:	

Part II – Particulars of Certificate Preferred for Claim (in Descending Order of Preference) – Only applicable for Hospital and Surgical claim

If the Person Covered is covered by more than one takaful certificate or rider which grants Hospital and Surgical Benefit issued by the Company, you must decide which certificate or riders you are making a claim under; if you do not decide, the Company will in its sole discretion make a decision on your behalf. A decision once made is final and you will not be allowed to subsequently make the claim under another certificate or rider.

1st Preference: (Certificate No. and Rider)	2nd Preference: (Certificate No. and Rider)
3rd Preference: (Certificate No. and Rider)	4th Preference: (Certificate No. and Rider)

Part III – Particulars of Person Covered's (Event Person's) Employment Details

1. Occupation:	2. Name of Employer:
3. Nature of business:	4. Contact No.:
5. Date First Employed (dd/mm/yyyy):	6. Address of Employer:

Part IV – Particulars of Accident

1. Date and Time (dd/mm/yyyy): am / pm	2. Place:
3. Describe fully how the accident occurred:	4. If injuries/ dismemberment were not due to accident, please provide underlying cause:
5. State as precisely the injuries you have sustained, indicating the part of the body injured and the type of injury (e.g. fracture, cut, bruise, etc.).	6. a) Date last attended work (dd/mm/yyyy): b) Date returned to work (dd/mm/yyyy):
7. Day(s) of medical leave:	

Part V – Particulars of The Illness / Disability

1. Nature of illness / disability:	2. Date of diagnosis (dd/mm/yyyy):
3. Date symptom(s) first noted (dd/mm/yyyy):	4. Duration of symptom(s):
5. Symptom(s) of illness / disability:	6. Name of hospital admitted:
7. Date of admission (dd/mm/yyyy):	8. Date of discharge (dd/mm/yyyy):

Part VI – Particulars on Doctors Consulted

	First Treatment Date (dd/mm/yyyy)	Name and Address of Doctor(s)
1. First doctor consulted for this illness / disability.		
2. All other doctors consulted for this illness / disability.		
3. Regular doctors.		
4. All other doctors consulted in the past five (5) years.		

Part VII – Particulars on Past Medical History

	Date of Diagnosis/ Onset (dd/mm/yyyy)	Name & Address of Doctor(s) Consulted	Dates of Consultation (dd/mm/yyyy)
1. Hypertension.			
2. Diabetes Mellitus.			
3. Cardiovascular Disease.			
4. Other Illnesses / Injuries. Please specify: a) b)	a) b)	a) b)	a) b)

Part VIII – Particulars on Other Policy / Certificate

Name of Insurance Company / Takaful Operator	Policy No. / Certificate No.	Policy / Certificate Effective Date (dd/mm/yyyy)	Sum Assured / Covered

Part IX- Details for Direct Credit / E-payment for Claim Payment

Single owned account is preferred but in the case of jointly owned account, the payee's name has to appear as the first account holder. In the event that you had provided the bank details to Claims Department earlier but you wish to deposit the claim monies into another bank account, please fill up the Details for Direct Credit / E-payment under Part V. Otherwise, payment will be made to the latest bank account submitted to Claims Department.

1. Name of Payee:	2. Designation/Occupation of Payee:
3. New IC No./Passport No. of Payee:	4. Date of Birth of Payee (dd/mm/yyyy):
5. Payee's Nationality:	6. Payee's Contact No: Email Address:
7. Payee's Residential Address:	8. Payee's Mailing/Correspondence Address:
9. Name of Payee's Bank:	10. Payee's Bank Account Number:

Part X- Particulars of Certificate Holder/ Beneficial Owner

1. Details of Certificate Holder

1. Name of Certificate Holder:	2. New IC No./Passport No.:

2. Details of Beneficial Owner (For Certificate Owned By Entity)

a) Entity Name:

b) Entity Registration No.:

In the event of the space provided is insufficient, please provide the information by attaching separate declaration forms.

	Beneficial Owner 1	Beneficial Owner 2	Beneficial Owner 3
Name			
Designation/Occupation			
New IC No./Passport No.			
Date of Birth (dd/mm/yyyy)			
Nationality			
Contact No.			
Residential Address			
Mailing/Correspondence Address			

3. Politically Exposed Person (PEP) Declaration

Note:

1. All names as per NRIC/Passport.
2. Politically Exposed Persons (PEP)
   (a) are individuals who are or who have been entrusted with prominent public function (Head of State or Government, Senior government, judiciary or military officials, senior executives of state-owned corporations and important political Party officials).
   (b) persons who are or have been entrusted with a prominent function by an international organization which refers Members of senior management. (Directors,deputy directors and members of the board or equivalent functions.
3. Family Members and Close Associates
   (a)Family Members are individuals who are related to a PEP, either directly (consanguinity) or through marriage. This includes parents*, siblings*, spouse(s), child* or spouse's parents* (*biological and non-biological relationship).
   (b) Close Associates is any individual closely connected to a PEP, either socially or professionally and may include extended family members such as relatives (biological or non-biological relationship), financially dependent individuals (persons salaried by the PEP such as drivers, bodyguard, secretaries, business partners or associate, prominent members of the same organization as the PEP, individuals working closely with the PEP i.e. work colleagues, close friend).
4. Beneficial Owner
   Refers to any natural person(s) who ultimately owns or controls a Person Covered and/or the natural person on whose behalf a Transaction is being conducted. It also includes those natural persons who exercise ultimate effective control over a legal person or arrangement. Reference to "ultimately owns or control" or "ultimate effective control" refers to situations in which ownership or control is exercised through a chain of ownership or by means of control other than direct control. This also refers to any natural person(s) who ultimately owns or controls a beneficiary, where specified in this document.

Please tick (√) the appropriate box

1. Does any Person Covered, Certificate Holder(s) hold or Beneficial Owner(s) hold, or has previously held or is being considered for a prominent public position?

☐ Yes ☐ No

If yes, please elaborate:

Name of Person Covered, Certificate Holder(s) or Beneficial Owners(s)	Position Held	No. of Years

2. Does any of the Person Covered, Certificate Holder(s) or Beneficial Owner(s)'s immediate Family Members/Close Associates hold, or previously held or is being considered for prominent public position?

☐ Yes ☐ No

If yes, please elaborate:

Name of Person Covered, Certificate Holder(s) or Beneficial Owner(s)	Details of Immediate Family Members/Close Associates			
	Name	NRIC/Passport No.	Position Held	Relationship to Person Covered, Certificate Holder(s)

Part XI – Declaration and Authorisation

I, the Certificate Holder hereby make a claim from Hong Leong MSIG Takaful Berhad ("the Company") in respect of the certificate monies payable on the condition / illness / disability of the Person Covered and / or the benefits due under Certificate No. _____ and agree that the written statements, reports and affidavits of any doctor who was consulted by the Person Covered or who attended to the Person Covered and all other documents furnished to the Company in support of this claim shall constitute and are hereby made a part of the proof of the condition / illness / disability of Person Covered.

2. I declare that the answers and statements given in the claim form submitted herewith are true and complete to the best of my knowledge and belief and that I have not withheld any material fact in my giving of the answers and statements.

3. I acknowledge and agree that the furnishing of this form or of any other form or document to me by the Company for completion, the acceptance of this form or of any other form or document by the Company from me or from any other person, and any act, enquiry or investigation by the Company in connection with or related to the condition / illness / disability of the Person Covered shall not constitute or be considered an admission of any liability by the Company or that there was any cover in force on the condition / illness / disability of the Person Covered, or that the Company has waived any of its rights or defences.

4. I, _____ New IC No./Passport No. _____ the Person Covered / Parent of Person Covered if Person Covered is below age 18 hereby authorise any employers, doctors, hospitals, clinics, takaful operators, government offices or any organizations or persons who have any records, knowledge or information, whether medical or otherwise, of _____New IC No./Passport No. _____ to disclose to the Company such records, knowledge or information for the purpose of claim considerations.

5. I hereby consent to the deduction of any amount which may be owed by me to the Company, whether under this Certificate or any other certificate which I may have with the Company, from the amount payable to me in respect of the claim I am now making.

6. A photocopy of this Declaration and Authorisation shall be as valid as the original.

Dated this _____ day of _____

_____
Signature of Witness

Name :

New IC No./Passport No.:

Address :

_____
Signature of Parent of Person Covered if Person Covered is below age 18

Name :

New IC No./Passport No.:

Address :

Email Address :

Contact No. :

_____
Signature of Witness

Name :

New IC No./Passport No.:

Address :

_____
Signature of Person Covered if Person Covered is above age 18 and is not the same person as the Certificate Holder

Name :

New IC No./Passport No.:

Contact No. :

_____
Signature of Witness

Name :

New IC No./Passport No.:

Address :

_____
Signature of Certificate Holder / Group Certificate Holder

Name :

New IC No./Passport No.:

Relationship to the Person Covered:

Designation :
(Please affix official stamp if Certificate Holder is an entity.)

	Requirements	Hospital & Surgical Benefit	Hospitalisation Benefit / Hospital Income Benefit	Accidental Medical Reimbursement/ Weekly Indemnity
1.	Hospitalisation Benefit / Hospital Income / Hospital & Surgical / Accidental Medical Reimbursement/ Weekly Indemnity Application Form This form is to be completed by the person entitled to the certificate monies.	✓	✓	✓
2.	Medical Attendant's Report on Hospitalisation Benefit / Hospital Income / Hospital & Surgical / Accidental Medical Reimbursement/ Weekly Indemnity Claim This report must be completed by a registered medical practitioner at the Claimant's own expenses.	✓	✓	✓
3.	Original Itemised Hospital Bill(s) Original copies of itemised hospital bill(s) are required. If original copy is lost, a statutory declaration of lost must be declared and signed before a Commissioner for Oaths. An original sighted copy of the lost bill by issuing party needs to be submitted.	✓		✓
4.	Photocopy Itemised Hospital Bill(s) A photocopy of itemised hospital bill is required to prove the number of admission days.		✓	
5.	Official Receipt / Tax Invoice Original copies of receipt(s) and tax invoice(s) are required. If original copy is lost, a statutory declaration of lost must be declared and signed before a Commissioner for Oaths. An original sighted copy of the lost official receipt by issuing party needs to be submitted.	✓		✓
6.	Confirmation Letter On Incurred Expenses Being Reimbursed By Other Party Applicable if part of the medical expenses has been reimbursed / paid by other party such as Other Insurer / Takaful Operator / Employer / Socso etc. It is applicable for medical expenses reimbursement under Accidental Medical Reimbursement/ Weekly Indemnity claim.	✓		✓
7.	Birth Certificate / Identity Card (for non-foreigner) / Passport (for foreigner) A photocopy of event person's birth certificate, identity card (for non-foreigner) / passport (for foreigner) is required to prove event person's age if the age has not been admitted at time of takaful application.	✓	✓	✓
8.	Patient Card A photocopy of event person's patient card is required to facilitate extraction of medical reports by hospitals / clinics.	✓	✓	✓
9.	Payee's identity card (for non-foreigner) / passport (for foreigner) A photocopy of payee's identity card (for non-foreigner) / passport (for foreigner) for claim payment via Direct Credit / E-payment is required.	✓	✓	✓
10.	X-Ray Report A photocopy of the x-ray report for fracture injury, dislocation of bone and amputation injury.	✓		✓
11.	Medical Leaves / Light Duty Certificate(s) A photocopy of medical leave / light duty certificate(s) is / are required for claim on temporary disablement indemnity benefit. This serves only as a guide for company on assessing the claim.			✓
12.	Newspaper Cuttings This is required if the incident is reported in the newspaper.	✓	✓	✓
13.	Police Report Original sighted copy of police report is required if event is related to accident or loss of travelling documents.	✓	✓	✓
14.	Certification / Letter from Person Covered's Home Embassy located overseas on the loss of Passport (Inclusive of Visa, if any) To prove the loss and replacement of Passport / Visa.			
15.	A photocopy of Certificate Holder/ Beneficial Owner's identity card (for non-foreigner) / passport (for foreigner).	✓	✓	✓
	Note: 1. Certification of documents as "Original Sighted" should only be done by either Solicitor and/or Hong Leong MSIG Takaful Branch Executive. Our company reserves the right to call for the original documents if the case warrants the sighting of the original documents during the course of the claim processing.			