Hospital Confinement 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*

Information of 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:				

Claim information

If due to **sickness**, please provide full details of the disease:				
Date symptom first presented (dd/mm/yyyy):				
Have you ever suffered from this symptom before?	☐ Yes, when (dd/mm/yyyy):		☐ No	
If due to **accident**, please provide date of accident (dd/mm/yyyy):		Time (am/pm):	Location:	
Details of the accident:				
Details of injuries sustained:				
When did you first consult a Medical Practitioner in connection with the condition?	Date (dd/mm/yyyy):	Name of doctor:		
	Name of hospital/clinic:			
Do you have any other insurance policy / or made a claim from any other insurance besides Etiqa?	☐ Yes, please provide:		☐ No	
	Policy no:			
	Insurance co.:			

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:

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:		
Type:	☐ Illness	☐ Injury
Diagnosis:		
If **injury**, when did the accident occurr?		
Do you think the patient was intoxicated with alcohol or drugs at the time of accident?	☐ Yes	☐ No
If **sickness**, when did the symptom first occur?		
Were there any underlying cause/ pathology that contributed to the above diagnosis?		
Does the patient have any pre-existing illness/ congenital condition?		
When did the patient first refer to you in connection with the above condition?		
What was the patient's complaint?	Yes, please provide name of doctor & hospital/ clinic:	
Has the patient ever had this illness or any similar condition before but has recovered?	☐ Yes, please provide details:	☐ No
Are you the patient's usual medical attendant?	☐ Yes	☐ No
Has the patient ever sought treatment for this condition elsewhere other than you?	☐ Yes Name of doctor: Name of hospital / clinic:	☐ No
Were there any investigations, tests or procedures performed?	☐ Yes, please provide details:	☐ No
Was a biopsy done to confirm whether the cells/ tissues are cancerous? *(for cancer patient only)*		
Is the diagnosis being confirmed by histological evidence of malignancy?		
For heart attack, is the diagnosis made based on history of typical prolonged chest pain/ new ECG changes/ elevation of cardiac enzymes?		
For the diagnosis of stroke, is there any documented evidence of permanent neurological deficit?		

Details of admission

Please provide details of treatment(s) during this admission:			
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)::
If hospitalization is continuous for 5 days or more, please indicate whether this is upon request of the patient?			
At the time of admission to hospital, was the patient:		☐ Pregnant ☐ Undergoing treatment for any mental disease or disorder	☐ Taking drugs or medication ☐ Undergoing treatment for HIV

Details of death

Date of death (dd/mm/yyyy):	
Please provide details on the cause of death:	

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.:

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Claim Assist 1300 88 1007

Ahli Kumpulan Maybank