

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? <input type="checkbox"/> Yes, when (dd/mm/yyyy): <input type="checkbox"/> 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?	<input type="checkbox"/>	Yes, please provide:		<input type="checkbox"/>
		Policy no:		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:	<input type="checkbox"/> Illness	<input type="checkbox"/> Injury
Diagnosis:		
If injury , when did the accident occur?		
Do you think the patient was intoxicated with alcohol or drugs at the time of accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes, please provide details:	<input type="checkbox"/> No
Are you the patient's usual medical attendant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient ever sought treatment for this condition elsewhere other than you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Name of doctor:	
	Name of hospital / clinic:	
Were there any investigations, tests or procedures performed?	<input type="checkbox"/> Yes, please provide details:	<input type="checkbox"/> No
Was a biopsy done to confirm whether the cells/ tissues are cancerous? <i>(for cancer patient only)</i>		
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:	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Taking drugs or medication	
	<input type="checkbox"/> Undergoing treatment for any mental disease or disorder	<input type="checkbox"/> 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.: