TAKAFUL IKHLAS FAMILY BERHAD (593075 U)
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BORANG TUNTUTAN HOSPITAL & PEMBEDAHAN
HOSPITAL & SURGICAL CLAIM FORM

Penyerahan Tuntutan - SENARAI SEMAK
Submission of Claims - CHECKLIST

- ☐ Resit Asal / *Original Receipt*
- ☐ Bil Terperinci / *Itemised Bill*
- ☐ Laporan Perubatan / *Medical Report*
- ☐ Surat Rujukan (Jika ada) / *Refferal Letter (If any)*
- ☐ Laporan Makmal / *Lab Report*
- ☐ Nota Discaj / *Discharge Note*
- ☐ Salinan Muka Hadapan Buku Bank / *Copy of the Front Page of Account Passbook*
- ☐ Salinan Laporan Polis Yang Disahkan (Kes Kemalangan) / *Certified True Copy of Police Report (Accidental Case)*
- ☐ Salinan Kad Pengenalan Peserta / *Copy of participants NRIC*

Nota:
- Dokumen-dokumen untuk setiap jenis tuntutan seperti yang dinyatakan **MESTI** dilampirkan bersama dengan borang tuntutan ini untuk pemprosesan tuntutan.
- Tuntutan tidak akan diproses bagi ubat-ubatan yang dibeli secara terus dari farmasi dan tanpa preskripsi doktor.
- Tuntutan akan dikembalikan jika Resit Asal & Bil Terperinci untuk kos setiap ubat / vaksinasi / suntikan / ujian makmal / x-ray / laporan perubatan tidak disertakan.

Note:
- *Documents for each type of claim as stated **MUST** be attached with this form for claim processing.*
- *Claims for medication purchased directly from a pharmacy without a copy of the doctor's prescription slip will NOT be processed.*
- *Claims without original receipt and breakdown of charges for each medication / vaccination / injection / lab tests / x-ray / medical report will be returned.*

JENIS TUNTUTAN / *TYPE OF CLAIM*

Sila tanda (√) di dalam kotak berkenaan / Please tick (√) in the appropriate box.

- ☐ *Hospitalisation / Day Surgery*
- ☐ *Others (Unutilised R&B)*
- ☐ *Chemotherapy or Physiotherapy or Dialysis*
- ☐ *Outpatient Accidental or Outpatient Dental Accidental Treatment*
- ☐ *Outpatient Treatment Pre and Post (No Medical Report Required)*
- ☐ *Government Hospital Daily Cash Allowance*

A. MAKLUMAT PEMEGANG SIJIL/ CERTIFICATE OWNER'S

Nama Pemegang sijil / Peserta (seperti di dalam KP) *Name of Cerificate owner / Participant (as in IC)*

Tarikh Lahir Pemegang Sijil / *Birth Date of Certificate Owner* (- -)

No. Kad Pengenalan Ahli / *Employee's NRIC No.*

Pekerjaan / *Occupation*

No. Sijil / *Certificate No*

No. Tel / *Tel No.*

Alamat Surat Menyurat / *Current Correspondence Address*

Poskod / *Postcode* Bandar / *Town*

Negeri / *State* E-mel / Email :

B. MAKLUMAT SYARIKAT/ COMPANY INFORMATION *(Untuk Sijil Berkelompok / For Group Certificate Only)*

Nama Syarikat / Majikan / Company Name / Employer

Alamat Surat Menyurat Syarikat / *Current Company Correspondence Address*

Poskod / *Postcode* Bandar / *Town*

Negeri / *State* No. Tel / *Tel No.*

C. MAKLUMAT EJEN (Untuk Sijil Individu Sahaja) / *AGENT'S INFORMATION* (*For individual Ceritificate Only*)

Nama Ejen / *Agent's Name* _____ Kod Ejen / *Agent's Code*

Alamat Surat Menyurat Ejen / *Agent's Current Correspondence Address*

No. Telefon Ejen / *Agent's Contact No.*

E-mel Ejen / *Agent's E-mail* _____

D. MAKLUMAT PENUNTUT / PESAKIT / *CLAIMANT / PATIENT INFORMATION*

Nama Penuntut / Pesakit / *Name of Claimant / Patient*

Perhubungan dengan Pemegang Sijil / *Relationship to Certificate Owner*

☐ Diri Sendiri / *Self*
☐ Suami/Isteri / *Spouse*
☐ Anak / *Child*

Pelan / *Plan* ☐

E-mel / *E-mail* _____

Jantina Penuntut / *Sex of Claimant*

☐ Lelaki / *Male*
☐ Perempuan / *Female*

NRIC Penuntut / *NRIC Claimant* ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐

Umur / *Age* ☐☐ No. Tel / *Tel No.* ☐☐☐☐☐☐☐☐☐☐

E. MAKLUMAT PENYAKIT / *DIAGNOSIS INFORMATION*

Sekiranya kemasukan ke hospital dan/atau rawatan disebabkan oleh penyakit dan kemalangan,sila kemukakan kenyataan anda dibawah
If hospitalisation and/or consultation was due to illness and accident,please furnish in your own words in the following details

☐ Dimasukkan ke Hospital / *Hospitalisation*

i) Tarikh & Masa Kemasukan Wad/*Date & Time of Admission* d d - m m - y y Masa /*Time* h h : m m

ii) Apakah gejala-gejala dan tanda-tanda yang dinyatakan kepada doktor yang merawat anda?
What were sign(s) and symptom(s) which you provided to the attending physician ?

_____

iii)Sudah berapa lama anda / Orang yang dilindungi mengalami gejala-gejala dan tanda-tanda tersebut ?
How long have you/ the Person Covered been having these sign(s) and symptom(s)

_____

iv)Apakah diagnosis yang telah dimaklumkan kepada anda oleh doktor yang merawat ?
What was the diagnosis informed to you by the attending doctor

_____

☐ Kemalangan / *Accident*

i)Tarikh & Masa Kemalangan *Date & Time of Accident* d d - m m - y y Masa /*Time* h h : m m

ii)Bagaimana ia berlaku / *State how it happened*

_____

F. MAKLUMAT PEMBAYARAN / *PAYMENT DETAILS*

Bayaran Tuntutan hendaklah dibayar kepada / *Payment of Claim is to be made to* :

☐ Syarikat / *Company* ☐ Pemegang Sijil / *Certificate Owner* ☐ Penuntut / *Claimant*

Nama Bank / *Bank Name*

Akaun Bank / *Account Bank*

G. BUTIR-BUTIR INSURAN LAIN, PERKESO, INSURANS PAMPASAN PEKERJA DAN LAIN-LAIN / *DETAILS OF OTHER INSURANCE POLICIES, SOCSO, WORKMEN'S COMPENSATION AND OTHERS*

Jenis Sijil / *Certificate Type* _____ No. Sijil / *Certificate No.* _____

Syarikat Insurans / Takaful / *Insurance / Takaful Company* _____

H. KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT / *AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION*

Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya / tanggungan saya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya / tanggungan saya termasuk latar belakang penuh perubatan saya / tanggungan saya semasa dimasukkan ke hospital / menjalani pembedahan, kepada TAKAFUL IKHLAS FAMILY BERHAD.

I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have my / ward has been observed or treated, to give full particulars about my / ward's health including my / ward's whole medical history in respect of this hospitalisation / survey, to the TAKAFUL IKHLAS FAMILY BERHAD.

I. PENGAKUAN / *DECLARATION*

Saya dengan ini membuat perakuan bahawa sepanjang pengetahuan saya kenyataan dan maklumat yang tersebut di atas adalah benar dan saya tidak menyembunyikan apa-apa keterangan daripada Pihak Takaful Ikhlas Family Berhad. Saya dengan ini juga bersetuju mana - mana doktor, orang perseorangan atau pihak yang diberi kuasa membenarkan Takaful Ikhlas Family Berhad meminta dan mengambil apa - apa maklumat yang diperlukan bagi mempertimbangkan permohonan saya ini.

I hereby declare that to the best of my knowledge and belief the foregoing particulars and information stated above are true and correct and that I have not concealed any particular form Takaful Ikhlas Family Berhad. I hereby give my consent to any doctor, individuals or authorized party / parties to allow Takaful Ikhlas Family Berhad to request and obtain any information deemed necessary in the consideration of my application.

Tandatangan Pesakit / Pihak Menuntut *Signature of Patient / Claimant* Tarikh / *Date :*	Tandatangan Pemegang Sijil / Peserta *Signature of Certificate Owner / Participant* Tarikh / *Date :*	Tandatangan Saksi / Ejen *Signature of Witness / Agent* Nama / *Name :* NRIC No. : Tarikh / *Date :* Hubungan / *Relationship :*

SEKSYEN III **Discharge Medical Report Form**
To be completed by the Attending Doctor (IN BLOCK LETTERS) **MNR No:**

Name of Hospital :

Address :

Name of patient :

NRIC No. :

Date and Time of Admission :
d d - m m - y y y y (hrs)

Date and Time of Discharge :
d d - m m - y y y y (hrs)

Name of Referring Doctor and Address :

Admitting Doctor :

Attending Doctors :

Speciality :

1a. Diagnosis / ICD Coding :

1b. Cause and Pathology (if applicable) of the above diagnosis :

2a. When did patient first consult you for this condition?
[ ] (dd) [ ] (mm) [ ] (yy)

2b. Was the patient previously treated for this condition? ☐No ☐Yes, give details and when
[ ] (dd) [ ] (mm) [ ] (yy)

2c. How long in your professional opinion has the condition existed?
[ ] (dd) [ ] (mm) [ ] (yy)

4a. Please √ Nature of Treatment and Investigation:
☐ OPERATION ☐ PHYSIOTHERAPY
☐ DIETARY COUNSELLING ☐ MEDICATIONS
☐ X-RAY ☐ BLOOD TESTS
☐ OTHERS, give details _____

4b. If more than one procedure was involved, please state Type of Procedures performed:

	TYPE	DATE	NAME OF DOCTOR
i.			
ii.			
iii.			

4c. Other medical conditions present?

Since (dd mm yy) _____

Since (dd mm yy) _____

Since (dd mm yy) _____

3. Any possibility of a relapse?
☐ Yes ☐No

5. Was the condition
☐ congenital ☐ nervous ☐ mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)
☐ No ☐Yes, _____ months

7. If the hospitalisation was due to accident, please indicate date / time of accident:
[ ] (dd) [ ] (mm) [ ] (yy) [ ] (hrs)

8. Discharge / Follow-up instructions :

Signature and Name of Attending Doctor

Hospital Stamp

Date