Personal Accident Claim Form

Important Notice:

- *The participant/policy holder/claimant must give complete and accurate information.*
- *For your easy accessibility, this claim form is made available at our website www.etiqa.com.my*

Claim Supporting Document Checklist

Document Name	***Claims Type***		
	Medical Expenses/ Hospitalization/ Ambulance Claims	***Permanent Disability Claim***	***Death Claim***
1. Admission/ Discharge note of hospital bills	X		
2. Original medical receipts (out-patient)	X		
3. Police report	X	X	
4. Original ambulance fee receipt	X		
5. Copy of MyKad/ Marriage certificate/ Birth certificate	X	X	X
6. Medical specialist report		X	
7. Full photograph of injured person & affected limbs (for amputation only)		X	
8. SOSCO notification		X	X
9. Death certificate			X
10. Burial permit			X
11. Post-mortem report (full)	X		X
12. Letter of administrator			X
13. Others (if any)	X	X	X

Information on policyholder

Policy no.:				
Name of policyholder:				
MyKad / Army / Police / Passport no./ Business registration no.:			Occupation:	
Contact details	Phone no.	Mobile:	House:	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:	House:	Office:
	Email:			
Address Postcode	Town	State		Country
Relationship of patient to policyholder:				

Details of accident

Date of accident (dd/mm/yyyy):		Time (am/pm):
Location of accident:		
Describe in detailed how the accident occurred:		
Describe the injuries sustained:		
Were you in a public transport at the time of accident?	☐ Yes	☐ No
	If yes, please specify the type of public transport:	

Witness/ witnesses details (if any):	Name		
	Address Postcode Town State Country		
	Mobile	House	Office
Doctor who attended the injured person:	Name		
	Address of hospital/ clinic Postcode Town State Country		
	Mobile	House	Office
Family doctor (if any):	Name		
	Address of hospital/ clinic Postcode Town State Country		
	Mobile	House	Office

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 General Insurance 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

Note: (a) For death claim, next-of-kin is to sign.
(b) For Senior PA policy, signature of the injured person is sufficient.

eTiQa Insurance

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:		
MyKad / Army / Police / Passport no.:		
Brief description of the injuries sustained:		
Were there any external and visible injuries or wound as a result of this accident? ☐ Yes ☐ No	If yes, please describe the extent of injuries including site and other characteristics / features as seen by you?	If no, please describe any other evidence that is consistent with the accident as claimed by the patient:
Are the injuries sustained consistent with the nature of the accident? ☐ Yes ☐ No	If no, was it contributed by other degenerative illness/ disease? (Please include details) Period the patient has been suffering from the illness/ disease:	
Are the injuries sustained contributed by osteoporosis, hernia bone disease, pathological fracture, physical deformity, mental or nervous disorder?	☐ Yes	☐ No
	If yes, is it: ☐ Pre-existing	☐ 1st time detected
	Please provide details:	
How was the patient treated? ☐ Out-patient ☐ In-patient (hospitalized)	If out-patient, please provide details:	
	Name of doctor:	
	Name of hospital/ clinic:	
Did the patient use the service of an ambulance?	☐ Yes	☐ No
Is this a follow-up treatment?	☐ Yes	☐ No
Is the patient recommended for nursing care at home?	☐ Yes	☐ No
Is the patient recommended to use any orthopedic equipment?	☐ Yes	☐ No
Do you think that the patient was intoxicated by alcohol or drug at the time of accident?	☐ Yes	☐ No

Details of hospitalization

Name of hospital/ clinic:			
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):
Was there a surgery performed?		☐ Yes	☐ No
Has biopsy been done? *(for cancer patient only)*		☐ Yes, please enclosed a copy of histopathology report should the cells/ tissues are confirmed to be cancerous.	☐ No
Date of surgery (dd/mm/yyyy):			Name of surgeon:

Details of temporary disability

Name of hospital/ clinic:		
Name of doctor:		
Period of temporary total disability (Medical Leave) issued:	From:	To:
Period of temporary partial disability (Light Duty) issued:	From:	To:

Details of permanent disability

Comment on disability of patient: (Claim documents must be submitted within 1 year from the date of the accident)

☐ No disability ☐ Disability in possible future ☐ Disability is apparent

If disability is apparent, please confirm the percentage (%) of disability sustained if patient had reached Max Medical Improvement (MMI):

Details of death

Date of death (dd/mm/yyyy):	
Death was due to:	☐ Accident ☐ Illness
Actual cause of death:	
Was it contributed partly by any degenerative illness?	
Was any blood specimen taken for drug/ alcohol test (toxicology)?	

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: