Claim No.: _____

HOSPITALISATION & SURGICAL REIMBURSEMENT CLAIM FORM

This form is to be completed by Participant / Certificate Holder.

1. a) Certificate No.	a)
b) Name of Participant.	b)
c) I/C No.	c)
d) Birth Certificate No. for minor.	d)
e) Date of Birth.	e)
f) Address.	f)
g) Please confirm if there is a change of address for us to update your records.	g) Yes ☐ No ☐
h) Telephone No.	h) House: Office:
i) Handphone No.	i)
j) E-mail Address.	j)
k) Particular Bank.	k)
l) Individual Saving Account No. / Corporate's Bank Account No. (Please enclose a certified true copy of the saving book / Corporate's confirmation letter on the Corporate's Bank Account No.)	l)

m) **For Unit Link Certificate only** Please tick (one option only) your preference to reinvest the excess claim payment / installment payment / periodic payment (if there is any):	m) Reinvest the certificate money. Yes ☐ No ☐
n) Please tick (one option only) your preference on how the claim cheque should be channelled to you:	n) ☐ To be collected at our HLMT branch: _____ (please indicate the location of our branch). ☐ To be delivered by your Agent. ☐ To be sent directly to the address mentioned in 1(f).
o) Present occupation (if more than one, please state all).	o)
p) Name of Employer.	p)
q) Address of Employer.	q)
r) Date employed.	r)
s) Name of policy owner.	s)
i) Telephone No.	i) House: Office:
ii) Handphone No.	ii)
iii) E-mail Address.	iii)
t) Relationship to Participant	t)
2. Other Coverage.	
a) Are you entitled to compensation from any other Insurer / Socso / other medical benefit? If yes, please complete:	a) Yes ☐ No ☐
b) The name of the Insurance Company.	b)

c) Certificate No. / Certificates Nos. d) Plan and sum assured of the insurance. e) The effective dates of the Certificate/ Certificates. f) The expiry dates of Certificate/ Certificates. .	c) d) e) f)
3. Please Complete If Hospitalisation Was Due To Accident. a) Date of accident. b) Time. c) Full circumstances of the accident. d) Describe the type of injuries sustained.	 a) b) AM PM c) d)
4. Please Complete If Hospitalisation Was Due To Illness: a) Name of illness. b) Describe the symptoms. c) Date symptoms first began. d) Duration of symptoms prior hospitalisation.	 a) b) c) d)
5. Details Of Doctors. a) Doctor first consulted for this illness / injury. b) Doctor who referred Participant to hospital.	Dates of consultations Name and Address of Doctor(s) a) b)

c) All other doctors consulted during the illness / injury.	c)
d) All doctors consulted previously if this condition had been treated previously.	d)
6. Details of Hospitalisation. a) Date of admission.	a)
b) Date of discharge.	b)
c) Name of hospital admitted.	c)
7. Others. a) Name and address of: i) Participant's Regular doctor.	a) Name of Doctor Address i)
ii) All doctors consulted by Participant in the past three (3) years.	ii)
8. Please complete if Participant is female. a) Was the Participant pregnant at the time of hospitalization?	a) Yes ☐ No ☐
b) If so, how many months?	b)

Please note that the Company may require clarification or further answers before the Claim may be considered.

Office Use Only:

- ❑ Completeness of form
- ❑ Updated Changes in Core System
- ❑ HQ
- ❑ Branch: _____

Checked by: _____ Date:_____/_____/_____
(rubber stamped)

DECLARATION

I HEREBY DECLARE that I have received / suffered the injuries / illness(es) described above, and warrant the truth of the foregoing particulars in every respect, and agree that if I have made, or I shall make, any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

UNDERTAKING

I, _____I/C No. (New) _____ (Old) _____ understand that the Letter of Guarantee is issued strictly for the treatment of the disability (illness and / or injury) as diagnosed before or during admission and conveyed to Hong Leong MSIG Takaful Berhad (HLMT) by Third Party Administrator (TPA) only. Should there by any treatment required on the disability (illness and / or injury) which is different from that earlier diagnosed, I agree that the costs incurred on such treatment shall be excluded from the Letter of Guarantee and I shall personally undertake to settle them with the hospital/clinic at my own expense.

I understand that the delivery of this claim form and the grant of Letter of Guarantee or payment to the hospital by HLMT or its representative relating to the claim as specified in the form shall not be in any way be construed as an admission of HLMT's liability for the said claim and any further claims arising subsequently. HLMT shall reserve all rights of evaluation of the claim's admissibility as it deems appropriate.

I am fully aware of the conditions in the Letter of Guarantee granted by HLMT for the medical expenses incurred as aforesaid specified in the claim form and the limits as applicable thereto and / or as prescribed in the medical insurance coverage under the abovementioned certificate. I hereby undertake to settle any medical expenses exceeding the amount provided for in the said Letter of Guarantee and / or certificate contract. I am fully aware and agree that HLMT shall reserve the right to recover from me and I hereby undertake to repay to HLMT, the full amount of any medical expenses which are not covered under the said Letter of Guarantee or certificate contract or not admissible for any reasons including any non-disclosure of material facts on my part, if such expenses had been previously incurred under the Letter of Guarantee granted or reimbursed to me by HLMT as the case may be.

هوع ليوع م. س. أ. ج. تكافل
HongLeong MSIG Takaful

AUTHORIZATION

I, hereby irrevocably authorize any employers, doctors, hospitals, clinics, insurance companies, government offices or any organizations or persons who have any records, knowledge or information, whether medical or otherwise, of *(myself / my child) _____ Birth Certificate No. _____ or I/C No. _____ to disclose, release or transfer to Hong Leong MSIG Takaful Berhad such records, knowledge or information for claim. A photocopy of this undertaking and authorization shall be as valid as the original and shall be equally binding on my assigns or successors.

* Please delete the inappropriate item.

Dated this _____ day of _____

_____
Signature of Witness

_____
Signature of * Certificate Holder/ Participant/ Parent of Participant for Participant below age 16

Name : _____

I/C No. : _____