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CLAIM NUMBER:

Part 6 / Bahagian 6 : Details of Claimant / Butir-butir Pihak Yang Menuntut

Please complete the following details if the claimant is other than the Participant / Sila lengkapkan buti-butir berikut sekiranya penerima bayaran manfaat selain daripada Peserta.

1. Name / Nama

[illegible]

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[illegible]

Part 7 / Bahagian 7: Medical Information Authorisation / Perakuan Peserta dan/atau Pihak Yang Menuntut

I hereby authorise any hospitals, surgeons medical practitioners or clinics or other persons who have attended or examined me or my child for any reasons to disclose any and all information with respect to any illnesses or injuries and to provide copies of all medical reports, including earlier medical history. A copy of this authorisation shall be considered as effective and valid as original. /

Bahawasanya dengan ini, adalah saya/kami membenarkan mana-mana hospital, pakar bedah, pegawai perubatan atau klinik atau orang perseorangan lain yang pernah merawat atau memeriksa saya atau anak saya atas apa jua sebab, untuk memberikan sebarang dan semua maklumat berkaitan penyakit atau kecederaan dan menyediakan salinan laporan perubatan termasuk sejarah perubatan terdahulu. Salinan kebenaran ini hendaklah juga dianggap sebagai sah sepertimana salinan asalnya.

$$\begin{array}{|c|c|} \hline & \\ \hline \end{array} \div \begin{array}{|c|c|} \hline & \\ \hline \end{array} = \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

Date (DD/MM/YYYY) /
Tarikh (HH/BB/TTTT)

Signature of person with disability or his/her guardian /
Tandatangan pihak yang mengalami keilatan atau penjaganya

Part 8 / Bahagian 8 : Declaration by Participant and Claimant / Perakuan Peserta dan/atau Pihak Yang Menuntut

I/We hereby declare that to the best of my/our knowledge, the above statements and facts are true and I/we did not falsify or provide any false statements to support this claim. /
 Bahwasanya dengan ini adalah saya/kami sepanjang pengetahuan saya/kami mengesahkan pernyataan-pernyataan yang terkandung di atas adalah benar dan betul dan saya/kami tidak memalsukan atau memberikan pernyataan yang tidak benar bersabit tuntutan tersebut.

If this form was completed by someone else, I/we hereby declare that all statements provided by them to be considered as statements provided by me/us and I/we shall be fully responsible for those statements. /
 Sekiranya borang ini diisi oleh orang lain bagi pihak saya/kami mengaku bahawa apa-apa pernyataan yang dibuat oleh mereka adalah disifatkan sebagai pernyataan saya/kami sendiri dan saya/kami mengaku bertanggungjawab dengan pernyataan-pernyataan tersebut.

I/We also declare that we shall fully cooperate with the Company and any other parties representing the Company in relation to this claim. /
 Saya/Kami seterusnya mengaku akan memberi kerjasama yang penuh dan sepatutnya kepada pihak Syarikat serta mana-mana pihak lain yang mewakili pihak Syarikat bersabit dengan tuntutan ini.

 /

 /

Date (DD/MM/YYYY) / Tarikh (HH/BB/TTTT) Participant's Signature / Tandatangan Peserta (Please affix Official Seal, if applicable) / (Sila letakan Cop Rasmi jika berkenaan) Claimant's Signature / Tandatangan Pihak Yang Menuntut

Part 9 / *Bahagian 9* : Verification of Identity / *Pengesahan Pengenalan*

I hereby certify that the participant's and claimant's original NRIC / Company Registration Certificate was verified and authenticated by me at the point of claim submission. / Saya dengan ini mengesahkan bahawa salinan asal kad pengenalan (KP) / Sijil Pendaftaran Syarikat peserta dan pihak yang menuntut telah disahkan ketulenannya ketika permohonan tuntutan dibuat.

Third Party Verification / Pengesahan Pihak Ketiga:

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"Third Party" means takaful agents, takaful brokers or staff of the Company / *"Pihak Ketiga"* bermaksud ejen takaful, broker takaful atau kakitangan pihak Syarikat.

Important Notice / *Notis Penting*

Please submit the following documents to support your claim / Sila sertakan dokumen-dokumen di bawah untuk yang menyokong tuntutan anda:

- | | | | | | |
|--------------------------|---|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Disability Claim Form For Group Family Takaful Plan / <i>Borang Keilatan Untuk Pelan Takaful Keluarga Takaful Berkelompok</i> | <input type="checkbox"/> | Certified copy of Medical Report / <i>Salinan Laporan Perubatan yang disahkan, sekiranya ada</i> | <input type="checkbox"/> | Certified copy of light duty entitlement. / <i>Salinan kelayakan tugas-tugas ringan yang disahkan.</i> |
| <input type="checkbox"/> | Certified copy of Identity Card of the person with disability / <i>Salinan Kad Pengenalan pihak yang mengalami keilatan yang disahkan</i> | <input type="checkbox"/> | | | |

Dokumen tambahan bagi tuntutan Keilatan Sementara Sepenuhnya.

- ☐ Certified copy of Police Report / *Salinan Laporan Polis yang disahkan* ☐ Certified copy of Medical Leave entitlement / *Salinan kelayakan tugas-tugas ringan yang disahkan.*

Additional documents for group family takaful plan / *Dokumen tambahan bagi pelan takaful keluarga berkelompok*

- ☐ Proof of membership e.g. members list, endorsement etc. / *Bukti penyertaan seperti senarai nama, endosmen dll.*

☐ Proof of relationship between member/employee of the participant and the person with disability if he/she was not a member/employee of the participant / *Bukti hubungan ahli/kakitangan ahli/kakitangan peserta dengan pihak yang mengalami keilatan sekiranya beliau bukanlah ahli/kakitangan peserta*

☐ Certified copy of Medical examination board decision. / *Salinan kelayakan tugas-tugas ringan yang disahkan.*

Additional documents for group family takaful plan (credit card) / Dokumen tambahan bagi pelan takaful keluarga berkelompok (kad kredit)

- ☐ Certified copy of payees Identity Card - if payment is to be made to beneficiary / *Salinan Kad Pengenalan sekiranya pembayaran di buat ke atas waris.*

- Proof of Net Asset Value (NAV), Balance of unit & unit price (Unit Trust) at his/her date of death. / *Bukti nilai asset bersih, baki unit dan nilai pada tarikh.*

Please note that the Company may require additional supporting documents to be submitted after the claim has been registered / Sila ambil maklum bahawa pihak Syarikat mungkin memerlukan dokumen-dokumen tambahan lain untuk diserahkan setelah tuntutan ini didefektakan.

Direct Credit Instruction / Arahan Pindahan Terus

Important Note : The account holder name and claimant must be the same person / **Nota Penting :** Nama Pemegang Akaun dan penandatangan arahan kredit mestilah sama dengan penuntut pada borang tuntutan.

E-Payment (Company) / E-Pembayaran (Syarikat)

Company Name / Nama Syarikat	
Company Registration No. / No. Pendaftaran Syarikat	
Address / Alamat	
Contact Person / Pegawai Dihubungi	
E-mail Address / Alamat E-mel	
Bank Name / Nama Bank	
Bank Account No. / No. Akaun Bank	<div style="display: flex; align-items: center;"> <div style="flex: 1; border-bottom: 1px solid black; position: relative;"> (16 digit) </div> <div style="background-color: #cccccc; width: 100px; height: 20px;"></div> </div>
SWIFT Code / Kod SWIFT	

Terms and Conditions / Terma-terma dan syarat-syarat

1. Please furnish a copy of the bank statement for verification purpose.
Sila kemukakan satu salinan penyata bank untuk tujuan pengesahan.
2. If the copy of bank statement is not provided, the Company is deemed to have confirmed the account details provided in this form as valid and accurate.
Jika salinan penyata bank tidak dikemukakan, Syarikat dianggap telah mengesahkan bahawa butir-butir akaun di dalam borang ini adalah sah dan tepat.
3. In the event of any invalid / inaccurate account details provided by the Company results in payment being credited into a third party bank account or if there is any loss incurred, the payment made thereto is still deemed as full payment and Takaful Malaysia shall be released and fully discharged from all existing and future liabilities, claims and demands in relation to such payment.
Sekiranya butir-butir yang diberikan oleh Syarikat tidak sah atau tidak tepat, mengakibatkan pembayaran Kredit Terus ke dalam akaun bank pihak ketiga atau sebarang kerugian, pembayaran dibuat itu masih dianggap pembayaran penuh dan Takaful Malaysia tidak akan bertanggungjawab atas segala liabiliti, dakwaan dan permintaan pada masa kini dan juga pada masa hadapan yang berkaitan dengan pembayaran tersebut.

Authorized Signatory /
Penandatangan Yang Dibenarkan

Company Stamp / Cop Syarikat

Name / Nama :
Designation / Jawatan :
Date / Tarikh :

MEDICAL CERTIFICATION FOR DISABILITY

THE FOLLOWING INFORMATION MUST BE COMPLETED BY ATTENDING PHYSICIAN. Please use separate sheet of paper if additional space is required.

A. DIAGNOSIS

1. Details of the exact diagnosis.

2. Date of onset of symptoms and date of any recurrences.

3. Date of the patient's first consultation with you for this condition.

4. When was the patient informed of the diagnosis?

5. To your knowledge please indicate the date from which the patient first become aware of the symptoms or conditions.

6. Was the patient being referred to you from another clinic/hospital?
If YES, please state the referring hospital?/clinic's address and telephone number.

7. Has the patient suffered any previous episodes of this condition or any condition leading to it or relating to it? If YES, please provide the details.

DateSymptomsDiagnosisTreatment

8. Has the patient undergone any surgical procedures for this any condition leading to it or relating to it? If YES, please provide the details.

DateSymptomsDiagnosisSurgical Procedures

B. DISABILITIES

1. What is the extent and severity of the patient's condition (eg. Is he/she able to commute by himself/herself? Is he/she able to concentrate on and complete the task by himself/herself, if so for how long?)

2. Is the patient's condition improving, stable or deteriorating?

3. Is the patient's condition permanent? If YES, please provide the estimated percentage of permanent disability against the 100% ability of its original function.

4. What is the extent of the patient's expected recovery from this condition?

5. When would the recovery be expected?

6. To what extent would the patient's current condition affect his/her ability to perform his/her usual occupation?

7. To what extent would the patient's ability to perform his/her usual occupation be affected after his/her expected recovery?

8. To what extent would the patient's current condition affected his/her ability to perform any other occupation?

9. To what extent would the patient's ability to perform any other occupation be affected after his/her exected recovery?

10. Is the patient capable of practising current occupation on a full-time or part-time basis?

11. Is the patient capable of practising other occupation? If yes, please describe type of work?

DISABILITY CLAIM FORM / BORANG TUNTUTAN KEILATAN

C. ACTIVITIES OF DAILY LIVING: Please comment on whether the patient is able to perform the following activities of daily living

Washing, bathing Ability to wash or bath or shower on by other means to maintain personal cleanliness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Dressing Ability to dress and undress and to put on and take off any medical appliance usually worn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Toileting Ability to do all of the following: to get to and from the lavatory, to get on and off the lavatory, to maintain adequate level of personal hygiene	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Continence Ability to voluntarily control bowel and bladder function with or without the use of catheters, incontinence or other artificial aids.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Feeding Ability to take any form of nourishment once it had been prepared and made available	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Mobility Ability to move in and out of a chair or bed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Restriction in movement or lifestyle? If so, please give details	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:

D. ACTIVITIES OF DAILY LIVING: Please comment on whether the patient is able to perform the following activities of daily living

Temporary Partial Disablement I hereby certify that the patient has suffered temporary partial disablement due to the above condition and has been able to perform only light duties of his usual duties or jobs during the following periods:	From: <input type="text"/> / <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/> / <input type="text"/>
Temporary Total Disablement I hereby certify that the patient has suffered temporary total disablement due to the above condition and has not been able to perform only of his usual duties or jobs during the following periods:	From: <input type="text"/> / <input type="text"/> / <input type="text"/> To: <input type="text"/> / <input type="text"/> / <input type="text"/>
Permanent Partial Disablement I hereby certify that the patient has suffered permanent partial disablement due to the above condition and the details are as follows:	Percentage of disability: <input type="text"/> % Please state which limbs and details of its disablement <hr/> <hr/>
Permanent Total Disablement I hereby certify that the patient has suffered permanent total disablement due to the above condition and the are as follows:	Please state which limbs and details of its disablement <hr/> <hr/> <hr/>
Please provide additional information, if any:	

E. DECLARATION BY THE ATTENDING PHYSICIAN

To the best of my knowledge, I hereby declare that all the information given above are true and accurate.

Name of patient: _____

NRIC/BC/Passport No.: _____ MRN: _____

Signature of Attending Physician: _____ Professional Qualifications: _____

Name: _____

Address: _____

Official Seal: _____

Date: _____