

## TOTAL & PERMANENT DISABILITY CLAIM FORM

### SECTION A

Every question must be fully answered. The Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

**Contract No :** \_\_\_\_\_

Agent's name & code :

Agent's Contact No. :

#### Instruction – Supporting documents required

- ☐ Total and Permanent Disability Claim form
- ☐ Total & Permanent Disability Statement of Medical Examiner
- ☐ Original certificate/policy contract
- ☐ Certified copy of Participant and/or Claimant's IC
- ☐ Letter of job termination from Participant's employer (if employed)
- ☐ Certified copy of clinic/ hospital consultation card
- ☐ Other supporting documents (if applicable)

Name of Participant \_\_\_\_\_

New IC No \_\_\_\_\_ Old IC No. \_\_\_\_\_ Age \_\_\_\_\_

Correspondence Address \_\_\_\_\_

Mobile Phone No. \_\_\_\_\_ E-mail address \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

What is the highest level of education do you have? ☐ Primary ☐ Secondary ☐ Tertiary ☐ Post graduate

#### 1 Please list the jobs held in the past 3 years

Dates (From -To) dd/mm/yyyy	Job Title & Employer's Address	Exact Duties of Work	Average monthly income (RM)

- 2 Name of the Employer prior to onset of disability \_\_\_\_\_
- 3 Address of Employer prior to onset of disability \_\_\_\_\_
- \_\_\_\_\_ Office Phone No. \_\_\_\_\_
- 4 Date of Employment \_\_\_\_\_ (dd/mm/yyyy)
- 5 Main duties prior to onset of disability \_\_\_\_\_
- 6 Work environment ☐ Factory ☐ Office ☐ Outdoors Type of industry \_\_\_\_\_
- 7 Are you in management or supervisory capacity? \_\_\_\_\_
- 8 Do you operate any machine or special equipments? ☐ Yes ☐ No
- 9 What is the qualification and/or skills needed for the job? \_\_\_\_\_
- 10 a. Any special skills required? \_\_\_\_\_
- b. What is your normal working hours and days? \_\_\_\_\_
- c. Are you required to work on shift, Sunday or on-call? \_\_\_\_\_
- d. Any travelling (km/week) required by the job? \_\_\_\_\_

11 Condition/Disability due to Accident

- a. When did the accident happen? Date: \_\_\_\_\_ (dd/mm/yyyy) Time : \_\_\_\_\_ (am/pm)
- b. Where did the accident happen? \_\_\_\_\_
- c. What were you doing at the time of Accident? \_\_\_\_\_
- d. Describe in detail how the Accident happened ? \_\_\_\_\_

12 Condition/Disability due to Illness

- a. Describe fully the symptoms for which you consulted a medical practitioner. \_\_\_\_\_
- b. Date symptoms **first** commenced \_\_\_\_\_ (dd/mm/yyyy)
- c. Date you **first** consulted doctor for this condition \_\_\_\_\_ (dd/mm/yyyy)
- d. Name & address of doctor you **first** consulted for this condition \_\_\_\_\_
- e. What was the diagnosis? \_\_\_\_\_
- f. What treatment are you currently receiving? \_\_\_\_\_
- g. Have you previously suffered from, or received treatment for a similar or related illness? ☐ Yes ☐ No
- If yes, please give full details \_\_\_\_\_
- h. State the name and address of your regular doctor \_\_\_\_\_
- i. Please give details of any other doctors you have consulted in connection with this or other conditions.

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

13 When were you last able to work? \_\_\_\_\_ (dd/mm/yyyy)

14 What aspects of your disability prevent you from following your occupation/any occupation?

15 State the date when you are expected to resume your work and daily activities \_\_\_\_\_ (dd/mm/yyyy)

16 Do you intent to seek another employment? ☐ Yes ☐ No

If yes, the nature of work \_\_\_\_\_

If no, why? \_\_\_\_\_

17 Employment termination date \_\_\_\_\_ (dd/mm/yyyy)

18 Are there other policies in force on your life taken with other companies ? ☐ Yes ☐ No

i. If yes, please give details:

Name of Company(s)	Commencement date (dd/mm/yyyy)	Contract no	Type of coverage	Sum assured

19 Please state your (the Claimant) bank account details in order for us to credit the payment directly into your bank account.

Bank : \_\_\_\_\_ Account no: \_\_\_\_\_

#### DECLARATION

I/We hereby declare that the foregoing answers and statements are complete and true to the best of my/our knowledge and belief, and that I/we have withheld no material facts from the Company.

\_\_\_\_\_  
Signature / Thumb print of Participant

Name \_\_\_\_\_

Date \_\_\_\_\_ (dd/mm/yyyy)

\_\_\_\_\_  
Signature / Thumb print of Claimant (if other than Participant)

Date \_\_\_\_\_

Full name \_\_\_\_\_

Contact No \_\_\_\_\_

Designation & Official stamp is required for Company or Bank:

\_\_\_\_\_  
Signature of Witness

Date \_\_\_\_\_

Full Name \_\_\_\_\_

NRIC No \_\_\_\_\_

Contact No \_\_\_\_\_

**LETTER OF AUTHORISATION / CONSENT  
TO OBTAIN FURTHER INFORMATION (LIVING TAKAFUL CLAIM)**

To Whom It May Concern,

Contract No \_\_\_\_\_

Dear Sir / Madam,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of employment, financial, health or medical history of myself ("the Participant") and to provide such information to Etiqa Takaful Berhad or its authorised agents and/or employees.

I expressly waived all provisions of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on myself in a professional and/or client capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may rise, in supplying such information requested by the Company.

This authorisation / consent is irrevocable and a copy of it will have the same effect and validity as the original.

\_\_\_\_\_  
Signature / Thumb print of Participant

Name \_\_\_\_\_

NRIC \_\_\_\_\_

Old IC \_\_\_\_\_

Birth Cert No. (if minor) \_\_\_\_\_

Tel No. \_\_\_\_\_

Date \_\_\_\_\_ (dd/mm/yyyy)

\_\_\_\_\_  
Signature of Contract holder (If Participant is a minor)

Name \_\_\_\_\_

NRIC \_\_\_\_\_

Old IC \_\_\_\_\_

Tel No \_\_\_\_\_

Date \_\_\_\_\_ (dd/mm/yyyy)