TAKAFULmalaysia

Syarikat Takaful Malaysia Keluarga Berhad (131646-K)
(Formerly known as Syarikat Takaful Malaysia Berhad)
HEAD OFFICE: 26th Floor, Annexe Block, Menara Takaful Malaysia,
No 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur,
P.O. Box 11483, 50746 Kuala Lumpur

W takaful-malaysia.com.my
T 1-300 88 252 385
F 603-22740237
E csu@takaful-malaysia.com.my

Group Medical Inpatient / TAKAFUL myClick MediPlus Claim Form

IMPORTANT NOTE :
1. One form for ONE admission & related Pre & Post visit.
2. Claim for hospitalisation & surgical expenses must be submitted within 90 days from the date of discharge or consultation.
3. For Overseas Treatment, kindly include Original Detailed Admission Bill showing details of each charges, Original Receipt & Medical Report. If the bills is in foreign language, kindly provide English translation. Claims Worksheet is required for any excesses of hospitalisation claim.

CHECKLIST ON SUBMISSION OF CLAIM DOCUMENTS

TYPE OF CLAIM

☐ Hospitalisation / Daycare Treatment	☐ Pre & Post Hospitalisation	☐ Accidental Claim
1. Original Receipt (Deposit & Final Payment). 2. Detailed Itemised Bill. 3. Medical Report / Section II of this form • For Government Hospital bill above RM1,000 • For Private Hospital bill above RM500. 4. Copy of Investigation Report [Lab / Imaging / Procedure Done (if any)]. 5. Physiotherapy Details - visit date & amount for each treatment session done (Advance Payment NOT accepted).	1. Original Receipt (Deposit & Final Payment. 2. Detailed Itemised Bill. 3. Copy of Investigation Report [Lab /Imaging / Procedure Done (if any)]. 4. Physiotherapy Details - visit date & amount for each treatment session done (Advance Payment NOT accepted).	1. Original Receipt (Deposit & Final Payment. 2. Detailed Itemised Bill. 3. Medical Report / Section II of this form • For Government Hospital bill above RM1,000 • For Private Hospital bill above RM500. 4. Copy of Investigation Report [Lab / Imaging / Procedure Done (if any)]. 5. Copy of Police Report (if any).

SECTION I – To be completed by the Employee / Patient (IN BLOCK LETTERS)
Remarks: All fields marked with (*) are compulsory.

A. EMPLOYEE INFORMATION

1 * Name of Employee (as in NRIC)

2 * Employee NRIC No. / Passport No _____ – _____ – _____

3. Policy No.

4 Plan

5. * Mobile No. _____ – _____

6. Gender ☐ Male ☐ Female

5 * Email Address

B. PATIENT INFORMATION

1 * Name of Patient ☐ Same as above

2 * Membership No. (as in Member ID Card)

3. Gender ☐ Male ☐ Female

C. DETAILS OF OTHER INSURANCE POLICIES

1	Policy Type:	2. Policy No.:	
3.	Insurance Company :	4. Annual Limit:	

D. CLAIM AMOUNT

* RM _____ . _____

E. DECLARATION AND AUTHORISATION

I/We confirm that the answers given are true and accurate. I/We, the undersigned that the Company's acceptance of this form is not an admission of the Companys liability of my/our claim.

I/We authorize any institution or individual that has any records or knowledge of my/our health and medical history to disclose such information to the Company's of its representative. I/We understand and agree that any personal information collected or held by the Company (whether through this application or otherwise obtained) may be used and disclosed by the Company to individuals/institutions related to and associated with the Company or any selected third party within or outside Malaysia such as reinsurers, claims investigation companies and industry associations to process this application.

The information may also be used to provide service for this and other financial products and to communicate with me/us. I/We hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same.

I/We agree that in the event I/We make, or have in the past made, any false or untrue statement and/or suppressed and/or concealed any material facts in respect of my/the insured's condition, the Company's shall absolutely forfeit my/the Insured's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

_____ Signature of Employee

_____ Date

F. DIRECT CREDIT INSTRUCTION

1	Bank Name	Important Note: 1. By default, approved claims payments will be credited into the bank account as provided by your Employer during membership enrolment. 2. If no bank account information is provided earlier, kindly provide us the information where to be treated as new enrolment of account number for this claim and future transactions. 3. The account holder name and claimant must be the same person.
	Bank Account Holder Name	
	Bank Account No.	
	Terms and Conditions 1. Direct Credit facility is only applicable for bank accounts maintained in Malaysia. For overseas customers, we will assess and allow overseas accounts on a case to case basis. 2. In the event of any invalid / inaccurate account details provided by Participant / Certificate Owner results in payment being credited into a third party bank account, the payment made thereto is still deemed as full payment for Refund / Surrender/ Partial Withdrawal / Claims /Cancellation/ Others and STMKB shall be released and fully discharged from all existing and future liabilities, claims and demands in relation to such Refund / Surrender / Partial Withdrawal / Claims / Cancellation / Others.	

G. SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS) – Please answer all questions

1	a) Patient Name	b) NRIC	c) Age	d) Gender
2	Admission Date and Time D D / M M / Y Y Y Y : (hrs)	3. Dicharge Date D D / M M / Y Y Y Y		
4	Date of MC D D / M M / Y Y Y Y to D D / M M / Y Y Y Y	No. of MC		
5	a) Symptoms / Conditions requiring admission	b) How long is patient aware of the condition:		
	c) Patient's BP / Temp / Pulse:			
	d) Date symptoms first appeared:	e) Date first consulted:		
6	a) Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No b) Was this patient referred? If Yes, please provide details: c) If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed: Date / Disease / Disorder / Details of Treatment / Hospitalisation / Doctor / Hospital / Clinic d) Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No If No, please provide reasons of admission:			
7	Any other medical / surgical conditions present? ☐ No ☐ Yes, details below: a)_____ since D D / M M / Y Y Y Y b)_____ since D D / M M / Y Y Y Y			
8	Final Diagnosis / ICD Coding i) ii) iii)	b) Cause and pathology of the diagnosis		
9	Treatment given / Investigation done (Please supply copy of all investigation results):			
10	a) Surgical procedures performed: MMA code / PHFSR Code:	Date of surgery / procedure: D D / M M / Y Y Y Y		
11	Treatment given / Investigation done (Please supply copy of all investigation results): a) ☐ Childbirth / Infertility / Caesarean Section / Miscarriage or any Complications b) ☐ Congenital / Hereditary Disease c) ☐ Influence of Drugs / Alcohol d) ☐ Nervous / Mental / Emotional / Sleeping Disorder e) ☐ Cosmetic Reason / Dental Care / Refractive Errors Correction f) ☐ AIDS / STD / VD / HIV g) ☐ Self-inflicted Injuries / Violation of Laws / Strike / Riots h) ☐ None of the above			
12	Was the patient pregnant at the time of hospitalization? (For Females Only) ☐ No ☐ Yes, _____months			
13	I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated above represent my medical opinion of his / condition. Name & Signature of Attending Doctor / Doctor / Hospital Stamp / Date			