



HOSPITALIZATION, SURGICAL & MEDICAL BENEFIT CLAIM FORM - PART I

Borang Tuntutan Kemasukan ke Hospital, Pembedahan & Perubatan - Bahagian I

Please complete the Claim form in full with capital letters and cross [x] boxes as appropriate. Leave blank for questions that are not applicable and do not remove any page. /
 Sila lengkapkan borang tuntutan kemalangan sepenuhnya dengan huruf besar dan pangkah [x] pada kotak-kotak di mana sesuai. Kosongkan sekiranya soalan tidak terpakai dan jangan
 keluarkan mukasurat.

CLAIMS INFORMATION / MAKLUMAT TUNTUTAN	POLICY INFORMATION / MAKLUMAT POLISI
<input type="checkbox"/> Hospitalisation / Surgical <input type="checkbox"/> IHP Claim <input type="checkbox"/> New <input type="checkbox"/> Appeal (Select)	Policy No./ No. Polisi <input style="width: 100px;" type="text"/>
AGENT INFORMATION / MAKLUMAT EJEN	
Reported by / Dilapor oleh : Relationship to Insured / Hubungan dengan Insured : Date of Disability / Tarikh Ketidak upayaan : <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 40px;" type="text"/> (DD/MM/YYYY) Cause / Akibat : <input type="checkbox"/> Accidental / Kemalangan <input type="checkbox"/> Illness / Penyakit	Agent Code / Kod Ejen <input style="width: 100px;" type="text"/> Agent Tel. No. / No. Tel. Ejen <input style="width: 20px;" type="text"/> - <input style="width: 80px;" type="text"/> Unit / Unit <input style="width: 40px;" type="text"/> Agency / Agensi <input style="width: 100px;" type="text"/> Service Center / Pusat Perkhidmatan <input style="width: 100px;" type="text"/>
INSURED INFORMATION / ORANG YANG DIINSURANSKAN	To be completed only for third party policy or minor insured / Hanya perlu dilengkapkan untuk polisi pihak ketiga atau orang yang diinsuranskan adalah di bawah umur. <input type="checkbox"/> CLAIMANT INFORMATION / MAKLUMAT PIHAK MENUNTUT
1. Full Name (as shown on IC/Passport) / Nama penuh (seperti di KP/Pasport) <input style="width: 100%; height: 20px;" type="text"/>	1. Full Name (as shown on IC/Passport) / Nama penuh (seperti di KP/Pasport) <input style="width: 100%; height: 20px;" type="text"/>
2. New NRIC / NRIC Baru <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>	2. New NRIC / NRIC Baru <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>
3. Old NRIC/Passport / NRIC Lama / Pasport <input style="width: 100px;" type="text"/>	3. Old NRIC/Passport / NRIC Lama / Pasport <input style="width: 100px;" type="text"/>
4. Occupation / Pekerjaan <input style="width: 100px;" type="text"/>	4. Occupation / Pekerjaan <input style="width: 100px;" type="text"/>
5. Correspondence Address / Alamat surat-menyurat <input style="width: 100%; height: 40px;" type="text"/> Postcode / Poskod <input style="width: 20px;" type="text"/> Town / Bandar <input style="width: 20px;" type="text"/> State / Negeri <input style="width: 100px;" type="text"/>	5. Correspondence Address / Alamat surat-menyurat <input style="width: 100%; height: 40px;" type="text"/> Postcode / Poskod <input style="width: 20px;" type="text"/> Town / Bandar <input style="width: 20px;" type="text"/> State / Negeri <input style="width: 100px;" type="text"/>
6. House Telephone No / No. Telefon Kediaman <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>	6. House Telephone No / No. Telefon Kediaman <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>
7. Handphone No / No. Telefon Bimbit <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>	7. Handphone No : No. Telefon Bimbit <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>
8. Email / E-mel <input style="width: 100px;" type="text"/>	8. Email / E-mel <input style="width: 100px;" type="text"/>
9. Business Address / Alamat Pejabat <input style="width: 100%; height: 40px;" type="text"/> Postcode / Poskod <input style="width: 20px;" type="text"/> Town / Bandar <input style="width: 20px;" type="text"/> State / Negeri <input style="width: 100px;" type="text"/>	9. Business Address / Alamat Pejabat <input style="width: 100%; height: 40px;" type="text"/> Postcode / Poskod <input style="width: 20px;" type="text"/> Town / Bandar <input style="width: 20px;" type="text"/> State / Negeri <input style="width: 100px;" type="text"/>
10. Office Telephone No / No. Telefon Pejabat <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>	10. Office Telephone No / No. Telefon Pejabat <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/>
FOR OFFICE USE ONLY	
Received Date : <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 40px;" type="text"/> Claim No. : <input style="width: 100px;" type="text"/>	
Received By : <input style="width: 100%; height: 20px;" type="text"/>	
Servicing Office : <input style="width: 100%; height: 20px;" type="text"/>	



HOSPITALIZATION, SURGICAL & MEDICAL BENEFIT CLAIM FORM - PART II

Borang Tuntutan Kemasukan ke Hospital, Pembedahan & Perubatan - Bahagian II

Instruction / Arahan

- Itemised original bills and official receipts covering hospitalisation and surgical expenses for which claim is made must be attached. / Bil terperinci dan resit rasmi asal meliputi perbelanjaan kemasukan ke hospital dan pembedahan berhubung dengan tuntutan yang dibuat hendaklah disertakan.
- This form and the medical certificate annexed, must be completed and returned within ninety (90) days from date of discharge / date on which claimable expenses were incurred. / Borang ini dan lampiran sijil perubatan hendaklah dilengkapkan dan dikembalikan dalam tempoh sembilan puluh (90) hari dari tarikh keluar hospital/tarikh perbelanjaan yang boleh dituntut dikenakan.
- For any claim amount not exceeding RM 500.00 there is no necessary for submission of a medical report, (Part II of this form) unless expressly requested in writing by the company. However, the diagnosis and surgical procedure must be certified by the medical attendant on the bill. / Bagi sebarang tuntutan yang tidak melebihi RM500.00 laporan perubatan (Bahagian II borang ini) tidak perlu disertakan kecuali diminta secara bertulis oleh Syarikat. Bagaimanapun, prosedur pembedahan dan diagnosis hendaklah disahkan oleh doktor yang merawat di dalam bil-bil berkenaan.

To be completed by the Insured/Claimant / Hendaklah dilengkapkan oleh Orang Yang Diinsuranskan/Pihak Menuntut.

- If hospitalisation was due to accident, please furnish details of accident/ Jika dimasukkan ke hospital kerana kemalangan, sila nyatakan butir-butir kemalangan:-

(i) When did it occur? / Bila ianya berlaku?

Date / Tarikh : / /

D D M M Y Y Y Y

Time/ Masa : : am pm

(ii) Where did it occur? / Dimana ianya berlaku?

(iii) How did it occur? / Bagaimanakah ianya berlaku?

(iv) Nature & extent of injury / Jenis dan tahap kecederaan.

- If hospitalisation was due to other causes, please furnish / Jika dimasukkan ke hospital kerana sebab lain, sila nyatakan:-

(i) Nature of illness/symptom. / Jenis Penyakit/Gejala.

(ii) For how long had you / the life insured been having the symptom prior to first admission? /

Berapa lamakah anda/Orang Yang Diinsuranskan mempunyai gejala berkenaan sebelum dimasukkan ke hospital pada kali pertama?

Day/s Week/s Month/s Year/s
 Hari Minggu Bulan Tahun

(iii) What was the diagnosis? / Apakah diagnosisnya?

- Name and address of doctors who treated you/the Life Insured for this illness/injury/condition. / Nama dan alamat doktor-doktor yang merawat anda/Orang Yang Diinsuranskan untuk penyakit/kecederaan/keadaan ini.

(i) Date of Consultation / Tarikh Rawatan

/ /

D D M M Y Y Y Y

Date of Admission (If any) / Tarikh Kemasukan (Jika ada)

/ /

D D M M Y Y Y Y

Name / Nama :

Address / Alamat :

Postcode /
Poskod :

State /
Negeri :

(ii) Date of Consultation / Tarikh Rawatan

/ /

D D M M Y Y Y Y

Date of Admission (If any) / Tarikh Kemasukan (Jika ada)

/ /

D D M M Y Y Y Y

Name / Nama :

Address / Alamat :

Postcode /
Poskod :

State /
Negeri :



4. Please furnish name and address of your/the Life Insured's usual attending doctor other than above./

Sila nyatakan nama dan alamat doktor yang biasa merawat anda/Orang yang Diinsuranskan selain daripada doktor yang disebutkan di atas.

Name / Nama :

Address / Alamat :

Postcode / Poskod :

State / Negeri :

5. Are you/Is the Life Insured presently insured for Hospitalization & Surgical benefits under any Government Law / Program, employee benefit, any health benefit scheme or any other insurance policy?. / Adakah anda/Orang yang Diinsuranskan buat masa ini diinsuranskan untuk faedah Kemasukan Ke Hospital dan Pembedahan di bawah mana-mana Undang-undang/Program Kerajaan, faedah pekerja, mana-mana faedah skim kesihatan atau mana-mana polisi insurans?.

Yes / Ya No / Tidak

If so, please furnish details. / Jika ada, sila nyatakan butir-butir tersebut.

Policy/Membership No. / No. Polisi/Ahli

Name of Company/Program/Scheme / Nama syarikat/Program/Skim

(i)

(ii)

I / We hereby declare that the information given in this claim form are true and that I/the Life Insured did not suffer from any of the preexisting conditions at the time this policy was taken up. I further declare that current confinement to the hospital is not due to any causes which are stipulated in the Exclusion clause of the policy. I agree that in the event that I 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 life insured's health and condition, the company shall absolutely forfeit my/ the life insured's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

Saya/Kami dengan ini mengaku bahawa maklumat yang diberikan di dalam borang tuntutan ini adalah benar dan saya/orang yang Diinsuranskan tidak mengalami mana-mana syarat prawujud ketika polisi ini diambil. Saya seterusnya mengaku bahawa kemasukan dalam hospital berkenaan tidak disebabkan sebarang punca yang dinyatakan mengikut Fasal Pengecualian dalam polisi. Saya bersetuju jika membuat atau pada masa lalu pernah membuat, sebarang kenyataan palsu/tidak benar dan/atau melindungi dan/atau menyembunyi sebarang fakta matan berhubung dengan kesihatan/keadaan saya/Orang yang Diinsuranskan, Syarikat dengan secara mutlakinya akan melucutkan hak saya/Orang yang Diinsuranskan terhadap gantirugi dan seterusnya mempunyai hak untuk mengambil semula sebarang jumlah yang telah dibayar sebelum ini akibat daripadanya.

AUTHORIZATION / PEMBERIAN KUASA

I _____ NRIC No. _____ hereby authorize any physician, hospital, clinic or other organisation, institutions or persons, that have any records or knowledge of me/the Life Insured or my/Life Insured's health, to disclose to ING Insurance Berhad, or its representatives any and all such information and expressly waive on behalf of me/the Life Insured or any person who has any claim or interest in any policy issued hereunder, all provisions of law forbidding any physician or surgeon from disclosing any information acquired while attending me/ the Life Insured in a professional capacity. This authorization shall irrevocably bind my successors and assigns and remain valid, notwithstanding my/the Life Insured's death or incapacity and a copy of this authorization shall be as effective and valid as the original.

Saya _____ No.K/P _____ dengan ini memberikuasa kepada mana-mana doktor, hospital, klinik atau syarikat insurans atau mana-mana organisasi, institusi atau orang perseorangan, yang mempunyai rekod atau pengetahuan mengenai diri saya/Orang yang Diinsuranskan atau kesihatan saya/Orang yang Diinsuranskan, untuk mendedahkan kepada ING Insurance Berhad atau wakilnya, apa-apa dan segala maklumat tersebut. Pemberikuasaan ini mengikat, pengganti dan petugas saya secara muktamad dan kekal sah, walaupun saya/Orang yang Diinsuranskan meninggal dunia atau menjadi tidak berupaya dan salinan pemberikuasaan ini adalah berkesan dan sah seperti yang asal.

Signature of Witness / Tandatangan Saksi

Date / Tarikh: / /

D D M M Y Y Y Y

Name / Nama:

NRIC No. / No. K/P:

- -

Address / Alamat:

Postcode / Poskod: State / Negeri:

Contact No / No. Untuk dihubungi:

-

Relationship with patient / Hubungan dengan pesakit :

Signature of Life Insured/Claimant /

Tandatangan Orang Yang Diinsuranskan/Pihak Menuntut

Date / Tarikh : / /

D D M M Y Y Y Y



HOSPITALISATION CLAIM - CERTIFICATE OF MEDICAL ATTENDANT

(To be completed by the attending Doctor at Insured's Expense)

1. Patient's Name

NRIC No. - Admission No.

Date of Admission & Discharge Date/Time: From / / To / /

D D / M M / Y Y Y Y

From / / To / /

D D / M M / Y Y Y Y

Total No. of Days Warded (not inclusive of Home Leave) days

2. If hospitalization due to accident, please furnish

(a) Nature of Accident _____

(b) Date and time of Accident / / Time : : am pm

D D / M M / Y Y Y Y

3. The date on which you first saw the patient for this illness / injury / condition / /

D D / M M / Y Y Y Y

4. Was the patient referred to your hospital by any other doctor?
If yes, please indicate his/her name, address and contact no. Yes No

Name _____

Address _____

Postcode _____ State _____ Contact No _____

5. What were the symptoms the patient complained when he/she first saw you?

(i) According to patient, how long had she/he been experiencing these symptoms? Day/s Week/s Month/s Year/s

(ii) How long do you feel these symptoms had lasted? Day/s Week/s Month/s Year/s

6. Had patient previously received any treatment for above symptoms?
If yes, please furnish name, address of doctors and dates of consultation.

Name _____

Date : / /

Address _____

Postcode _____ State _____ Contact No _____

7. Have any investigation, test or procedure been performed? Yes No
If so, please furnish a certified true copy of the result.

8. What was your diagnosis?

9. Is this a congenital condition? Yes No

10. Did you inform the patient of the diagnosis? Yes No If so, when? Date : / /

D D / M M / Y Y Y Y

11. Nature of medical treatment given.



12. For surgery:-

(a) Nature of operation performed: _____

(b) Date surgery performed:

D	D

 /

M	M

 /

Y	Y	Y	Y

(c) Name of surgeon: _____

13. Any possibility of patient having relapse? Yes No

Has the patient previously been treated or hospitalized in this or any other hospital for this or any other disease? Yes No

If so, please state,

Date :

D	D

 /

M	M

 /

Y	Y	Y	Y

 Disease/Illness _____

Hospital/Clinic _____

Contact No _____

14. For female only

(a) Was the patient pregnant at time of hospitalization? Yes No

If yes, for how many months?

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 Months

(b) Was illness caused directly or indirectly by pregnancy/child birth/caesarian section / abortion / miscarriage and all complications arising therefrom?

Yes No

Declaration

"I hereby certify that the answers above are full, complete and true."

Signature of Physician

Name _____

NRIC No.

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Address _____

Postcode _____ Town _____

State _____ Contact No _____

Hospital/Clinic Stamp

Date :

D	D

 /

M	M

 /

Y	Y	Y	Y