ING

OUTPATIENT TREATMENT CLAIM FORM

This printed form is forwarded on receipt of notice of a claim and is no way admission of claim. It is Company's policy that all assistance provided in processing the claims by our agents or staff will be free of charge.

Agent's Name & Code: ..... Date and office issued: .....

Unit /Agency: .....

Agent's Tel. No.: .....

Service Centre: .....

Instruction

A) PRE & POST HOSPITALIZATION BENEFIT CLAIM / OUTPATIENT KIDNEY DIALYSIS / OUTPATIENT CANCER TREATMENT

1. Itemized original bills and official receipts must be attached.
2. For any single official receipt with claim amount exceeding RM500.00, either the original itemized bill or a breakdown of the bill with description is to be attached.
3. Diagnosis has to be stated on the receipt or bill and this to be certified by the Attending Doctor when treatment is sought from doctor or hospital other than that you were hospitalized in.

B) OUTPATIENT ACCIDENT TREATMENT BENEFIT CLAIM / OUTPATIENT SURGERY CLAIM

1. This form is applicable for claim amount less than RM500.00 under Section B.
2. Medical report is not necessary unless expressly requested in writing by the Company. However, the diagnosis / surgical procedure must be stated and certified by the medical attendant on the bill.
3. Itemized original bills and official receipts must be attached.

To be completed by the Insured/Claimant

1. INSURED'S INFORMATION

i. Policy No(s):	
ii. Name of Life Insured:	
iii. New NRIC:	Old NRIC/ Passport:
iv. Tel No:	v. E-mail

2. PRE AND POST HOSPITALIZATION CLAIM

Please furnish details of hospitalization for this pre-diagnostic/follow-up treatment:-

i. Admission Date: (dd/mm/yy)	ii. Discharge Date: (dd/mm/yy)
iii. Diagnosis:	
iv. Name of hospital you were admitted to:	

3. OUTPATIENT ACCIDENTAL TREATMENT CLAIM

Please furnish details:-

i. When did it occur? (dd/mm/yy)	At am/pm	/	❒ am ❒ pm
ii. Where did it occur?			
iii. How did it occur?			
iv. Nature and extent of injury:			

ING Insurance Berhad (17007-P)
LIFE BENEFITS, Menara ING, 84 Jalan Raja Chulan, P.O. Box 10846, 50927 Kuala Lumpur, Malaysia. **T** +603 2058 4838 **F** +603 2162 7471
Toll Free 1 800 88 0303 www.ing.com.my

4. OUTPATIENT SURGERY CLAIM

i. Surgery Date: (dd/mm/yy) - -

ii. Diagnosis:

iii. Name of hospital/clinic:

If claim due to accident, please furnish details:-

i. When did it occur? (dd/mm/yy) - - At am/pm / ❒ am ❒ pm

ii. Where did it occur?

iii. How did it occur?

iv. Nature and extent of injury:

5. OUTPATIENT KIDNEY DIALYSIS / OUTPATIENT CANCER TREATMENT CLAIM

i. Treatment Date: (dd/mm/yy) *from* - - *till* - -

ii. Diagnosis:

iii. Name of hospital/clinic:

6. Are you or 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? If so, please furnish details.

☐ Yes ☐ No

If so, please furnish details.

	Policy/Membership No.	Name of Company/Program/Scheme
i.		
ii.		

Declaration

I / We hereby declare that the information given in this claim form is true and that I/the Life Insured did not suffer from any of the pre-existing condition at the time of 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.

Authorization

I hereby authorize any physician, hospital, clinic or insurance company or other organization, 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.

Signature of Witness: _____ Signature of Insured/Claimant: _____

Name: _____ Name: _____ NRIC No.: _____

Relationship with insured: _____ If Claimant, state relationship with insured: _____

NRIC No.: _____ Date: _____