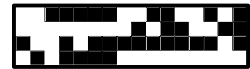

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ING Insurance Berhad (Co.No. 17007-P)
Life Benefits Department. Menara ING 50927 Kuala Lumpur, Malaysia
Tel : 03 2058 4838 Fax : 03 2162 7471 Toll Free 1 800 88 0303
http://www.ing.com.my

ACCIDENT CLAIM FORM - PART I
BORANG TUNTUTAN KEMALANGAN - 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*

☐ New ☐ Continuous ☐ Appeal (Select)

Reported by / *Dilapor oleh* :

Relationship to Insured / *Hubungan dengan Insured* :

Date of Accident / *Tarikh Kemalangan* : __ / __ / ____ (DD/MM/YYYY)

☐ Hospitalisation / *Kemasukan Hospital*

POLICY INFORMATION / *MAKLUMAT POLISI*

Policy No./ *No. Polisi*

AGENT INFORMATION / *MAKLUMAT EJEN*

Agent Code / *Kod Ejen*

Agent Tel. No. / *No. Tel. Ejen* -

Unit / *Unit*

Agency / *Agensi*

Service Center / *Pusat Perkhidmatan*

INSURED INFORMATION / *ORANG YANG DIINSURANSKAN*

1. Full Name (as shown on IC/Passport) / *Nama penuh (seperti di KP/Pasport)*
2. New NRIC / *NRIC Baru* - -
3. Old NRIC/Passport / *NRIC Lama / Pasport*
4. Occupation / *Pekerjaan*
5. Correspondence Address /*Alamat surat-menyurat*
   Postcode / *Poskod* Town / *Bandar*
   State / *Negeri*
6. House Telephone No / *No. Telefon Kediaman* -
7. Handphone No / *No. Telefon Bimbit* -
8. Email / *E-mel*
9. Business Address / *Alamat Pejabat*
   Postcode / *Poskod* Town / *Bandar*
   State / *Negeri*
10. Office Telephone No / *No. Telefon Pejabat* -

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.***

☐ CLAIMANT INFORMATION / *MAKLUMAT PIHAK MENUNTUT*

1. Full Name (as shown on IC/Passport) / *Nama penuh (seperti di KP/Pasport)*
2. New NRIC / *NRIC Baru* - -
3. Old NRIC/Passport / *NRIC Lama / Pasport*
4. Occupation / *Pekerjaan*
5. Correspondence Address /*Alamat surat-menyurat*
   Postcode / *Poskod* Town / *Bandar*
   State / *Negeri*
6. House Telephone No / *No. Telefon Kediaman* -
7. Handphone No : *No. Telefon Bimbit* -
8. Email / *E-mel*
9. Business Address / *Alamat Pejabat*
   Postcode / *Poskod* Town / *Bandar*
   State / *Negeri*
10. Office Telephone No / *No. Telefon Pejabat* -

FOR OFFICE USE ONLY

Received Date : __ / __ / ____ Claim No. :

Received By :

Servicing Office :

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ACCIDENT CLAIM FORM - PART II
BORANG TUNTUTAN KEMALANGAN - BAHAGIAN II

This printed form is forwarded on receipt of notice of an accident, and is no way admission of claim. /
Borang bercetak ini diberi di atas penerimaan notis kemalangan dan bukannya sebagai perakuan tuntutan.
It is Company's policy that all assistance provided in processing the claims by our agents or staff will be free of charge. /
Mengikut polisi syarikat, segala bantuan yang diberikan oleh ejen dan pekerja kami untuk memproses tuntutan dibuat secara percuma.

INSTRUCTION / ARAHAN

1. This form and the medical certificate annexed, must be completed and returned within 90 days of accident / loss. /
   Borang ini dan lampiran sijil perubatan yang disertakan hendaklah dilengkapkan dan dikembalikan dalam tempoh 90 hari selepas kemalangan / kehilangan.

2. Supporting documents required are: / *Dokumen sokongan yang diperlukan ialah:*
   - *a.* Original Medical Bills and official receipts for medical expenses reimbursement. / *Bil Perubatan dan Resit asal untuk pembayaran balik perbelanjaan perubatan.*
   - *b.* X-ray film or radiologist report for cases with fracture bones. / *Filem X-ray atau laporan pakar radiologi untuk kes tulang retak.*
   - *c.* Police Report for motor vehicle accident, assault and robbery cases. / *Laporan Polis bagi kemalangan kenderaan bermotor, kes-kes serangan dan rompakan.*
   - *d.* Photograph of dismemberment for permanent disability claim. / *Gambar-gambar perceraian anggota bagi tuntutan hilang upaya kekal.*
   - *e.* Newspaper cutting, if any. / *Keratan akhbar, jika ada.*

To Be Completed By The Assured / Claimant /
Hendaklah diisi oleh orang yang diinsuranskan / Pihak Menuntut

1. Exact nature of occupation and duties / *Jenis pekerjaan dan tugas* ______________________

Involved in manual work? / *Terlibat dalam kerja manual?* ☐ Yes / *Ya* ☐ No / *Tidak*

2. Particulars of Accident / *Butir terperinci kemalangan*

(a) When did it occur? / *Bila kemalangan berlaku?* Date / *Tarikh* : ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y) Time / *Masa* : ☐☐ : ☐☐ ☐ am ☐ pm

(b) Where did it occur? / *Di mana ia berlaku?*

____

(c) How did it occur? / *Bagaimana ia berlaku?*

____

(d) Nature and extent of injury / *Jenis dan tahap kecederaan.*

____

3. Information of doctor who treated you immediately after the accident / *Nama dan alamat doktor yang merawat sebaik sahaja selepas kemalangan.*

Full Name / *Nama Penuh*

Address / *Alamat* :

Postcode / *Poskod:* State / *Negeri:*

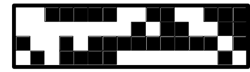
Telephone / *Telefon:* ☐☐☐ - ☐☐☐☐☐☐☐☐ Fax / *Faks:* ☐☐☐ - ☐☐☐☐☐☐☐☐

4. Was medical treatment sought immediately? / *Adakah rawatan perubatan didapat dengan segera.* ☐ Yes / *Ya* ☐ No / *Tidak*
If not, please explain why. / *Jika tidak, sila jelaskan sebabnya.*

____

5. (a) When were you first absent from work? / *Bilakah anda mula tidak hadir kerja?* ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y)

(b) Date of return to work? / *Tarikh kembali bekeria* ☐☐ / ☐☐ / ☐☐☐☐ (D D / M M / Y Y Y Y)



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6. Are you presently insured for accidental benefits under any Government Law or program including SOCSO, Employee Benefit Scheme or any other insurance policy / *Adakah anda sekarang diinsuran dengan faedah kemalangan di bawah sebarang program undang-undang kerajaan, termasuk SOCSO, mana-mana skim faedah pekerja atau lain-lain polisi insurans?*

☐ Yes / *Ya* ☐ No / *Tidak*

(a) Name of Co. / Program / *Nama Syarikat / Program*	(b) Policy / Membership No. / *No. Polisi / Keahlian*	(c) Amount of Benefit / *Jumlah Faedah*	(d) Date effected / *Tarikh berkuatkuasa*
		.	DD / MM / YYYY
		.	DD / MM / YYYY
		.	DD / MM / YYYY

I, hereby declare that I have sustained the injuries described above, and warrant the truth or the foregoing particulars in every respect, and agree that if I have made, or I shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Saya dengan ini mengisytiharkan bahawa saya telah mengalami kecederaan seperti yang dinyatakan di atas, dan menjamin bahawa butir-butir yang diberikan adalah benar dalam segala aspek dan bersetuju bahawa jika saya melakukan sebarang kenyataan palsu dan tidak benar, perlindungan dan penyembunyian sesuatu yang benar, hak saya dalam tuntutan ini akan ditarik balik.

AUTHORIZATION / *PEMBERIAN KUASA*

I, having read and understood the contents hereby authorize any physician, hospital, clinic or insurance company or other organization, institutions or persons that has any records or knowledge of me or my health, to disclose to ING Insurance Berhad or its representatives any and all such information and expressly waive on behalf of myself or any person who shall have 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 in a professional capacity. This authorization shall irrevocable bind my successors and assigns and remain valid, notwithstanding my death or incapacity and a copy of this shall be as effective and valid as the original.

Setelah membaca dan memahami kandungan tersebut, saya dengan ini memberi kuasa kepada mana-mana pakar perubatan, hospital, klinik atau syarikat insurans atau mana-mana organisasi, institusi atau orang perseorangan yang mengetahui atau mempunyai rekod mengenai diri dan kesihatan saya, untuk mendedahkan mana-mana atau segala maklumat tersebut kepada ING Insurance Berhad atau wakilnya dan secara langsung membatalkan mana-mana peruntukan bagi pihak saya atau pihak lain yang mempunyai tuntutan atau kepentingan dalam polisi menurut dokumen ini, yang melarang mana-mana pakar perubatan atau pembedahan daripada mendedahkan apa-apa maklumat yang diperolehi ketika merawat saya dalam kapasiti professional. Pemberian kuasa ini muktamad, merangkumi pengganti dan petugas saya dan kekal sah walaupun saya meninggal dunia atau tidak berkemampuan dan keberkesanan dan kesahihan salinan dokumen ini adalah sama seperti yang asal.

Signature of Witness / *Tandatangan saksi*

Date / *Tarikh* : DD / MM / YYYY

Signature of Insured/Claimant / *Tandatangan orang yang diinsuranskan/Pihak menuntut*

Date / *Tarikh* : DD / MM / YYYY

Name / *Nama* :

NRIC No. / *No. KP Baru* : - -

Address / *Alamat* :

Postcode / *Poskod:*

State / *Negeri:*

Telephone / *Telefon:* -

Relationship with Insured / *Hubungan dengan orang yang Diinsuranskan* ____

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CERTIFICATE OF MEDICAL ATTENDANT

NOTE : This medical certificate must be completed by a legally qualified and registered medical practitioner at the insured's own expense.

1. a) Patient's Name :

   b) NRIC (old) : NRIC (new) : - -

   c) Occupation : d) Age :

   e) Main duties f) Sex : ☐ Male ☐ Female

2. a) Date and time of accident : / / (D D / M M / Y Y Y Y) : ☐ am ☐ pm

   b) Date and time of first consultation : / / (D D / M M / Y Y Y Y) : ☐ am ☐ pm

3. Describe in detail the nature of accident as related to you by the patient.

4. a) Are the patient's symptoms solely due to this accident? ☐ Yes ☐ No

   b) If not, are they traceable to a previous injury or other cause? ☐ Yes ☐ No

5. a) Were there any external and visible injuries or wound as a result of this accident? ☐ Yes ☐ No

   b) If the answer to (a) is "No", describe any other evidence that is consistent with the accident as claimed by the patient.

   c) If the answer to (a) is "Yes", then describe the extent of injuries including site and other characteristics, features as seen by you.

6. Treatment given including follow-up (such as number of stitches, physiotherapy, type of dressing, etc.)

Date(s)	Condition	Treatment
D D / M M / Y Y Y Y		
/ /		
/ /		
/ /		
/ /		
/ /		

7. Fracture :

Fracture Type	Fracture Location	Treatment / management
Close Fracture		
Open Fracture		
Others		

8. a) If patient was put on any form of immobilization (POP, backslab, crepe, bandage, etc.), Please furnish us the date when it was applied and removed.

   Applied : / / (DD/MM/YYYY) Removed : / / (DD/MM/YYYY)

   b) If physiotherapy was necessary, please furnish us the dates the patient was on physiotherapy.

   From / / (DD/MM/YYYY) To / / (DD/MM/YYYY)

   c) Please furnish us the date that patient was started on Full Weight bearing / / (DD/MM/YYYY)

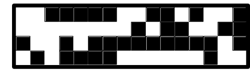
   (d) Was there any limitation of movement on any joint at the last date treatment ☐ Yes ☐ No

9. For amputation / loss of finger / toes. :

   (a) Which finger / toe was amputated?

Left					Right				
☐ Thumb	☐ Index finger	☐ Middle finger	☐ Ring finger	☐ Little finger	☐ Thumb	☐ Index finger	☐ Middle finger	☐ Ring finger	☐ Little finger
☐ Big toe	☐ 2nd toe	☐ 3rd toe	☐ 4th toe	☐ Little toe	☐ Big toe	☐ 2nd toe	☐ 3rd toe	☐ 4th toe	☐ Little toe

   (b) Amputation at what level? ☐ Proximal ☐ Middle ☐ Distal



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10. Was healing : ☐ Straight Forward ☐ Complicated

Please state details ______

11. Please state whether patient required :

a) X-ray ☐ Yes. Please furnish X-ray film and report ☐ No

b) Hospitalisation ☐ Yes. ______ ☐ No

Name of hospital : ______

Date admitted : __ / __ / ____ (DD/MM/YYYY) Date discharged : __ / __ / ____ (DD/MM/YYYY)

c) Surgery / other special diagnostic procedure or treatment ☐ Yes ☐ No

Please state type : ______

12. Name and address of other doctors (qualified & registered) who treated patient for the same injury.

(i) Name : ______

Address : ______

______

Postcode : ______ State : ______ Date : D D / M M / Y Y Y Y

(ii) Name : ______

Address : ______

______

Postcode : ______ State : ______ Date : D D / M M / Y Y Y Y

(iii) Name : ______

Address : ______

______

Postcode : ______ State : ______ Date : D D / M M / Y Y Y Y

13. In your opinion, is there any physical impairment or disease / illness which may have contributed directly or indirectly, to the accident, or which may likely retard his recovery? If 'yes', please provide details. ☐ Yes ☐ No

______

14. Last date of consultation. __ / __ / ____ (DD/MM/YYYY) (Condition of injured parts)

15. a) Bearing in mind the patient's occupation & duties as stated, do you feel that injuries would have prevented the patient from carrying out his / her main duties totally? ☐ Yes ☐ No

b) If your answer to the above is "No", please state specifically the main duties that patient could still perform.

______

c) If your answer to (a) is "Yes" and absence from work of more than two (2) weeks was necessary, please describe in detail the reason why you feel the patient could not return to work earlier. ______

Date : __ / __ / ____ (DD/MM/YYYY)

Physician's Signature

For identification purpose, the claimant must sign his / her name below in the presence of the physician.

Physician's Name : ______

Qualification : ______

Claimant's Signature

Affix Clinic / Hospital Stamp