TAKAFUL IKHLAS FAMILY BERHAD Registration No. 200201025412 (593075-U)
IKHLAS Point, Tower 11A, Avenue 5, Bangsar South,
No. 8, Jalan Kerinchi, 59200 Kuala Lumpur
Tel : 03-2723 9999 Fax : 03-2723 9998
IKHLAS Care : 03 2723 9696 Website: www.takaful-ikhlas.com.my

(Licensed under Islamic Financial Services Act 2013 and regulated by Bank Negara Malaysia)

BORANG TUNTUTAN - HOSPITAL DAN PEMBEDAHAN
CLAIM FORM - HOSPITAL & SURGICAL

Peringatan / *Reminders*

Penerimaan borang ini bukanlah bermakna dengan sendirinya tanggungan akan diakui oleh syarikat.
Acceptance of this form does not mean admission of liability by the company.

NO. SIJIL / *CERTIFICATE NO.* **:**

Jenis-jenis tuntutan (sila tandakan √ di petak yang berkenaan)
Boleh tanda (√) lebih dari 1 petak

Type of claims (please tick √ in the related box provided)
You may tick (√) more than 1 box

- ☐ Rawatan Hospital / Pembedahan Harian
  Hospitalisation / Day Care Surgery
  (Sila lengkapkan laporan perubatan pada Bahagian G/
  Please complete the medical report as per Section G)
- ☐ Rawatan Sebelum & Selepas Masuk Hospital
  Pre & Post Hospitalisation
- ☐ Rawatan Kecemasan Pesakit Luar Akibat Kemalangan
  Emergency Accidental Outpatient Treatment
- ☐ Lain-lain, sila nyatakan _____
  Others, please state
- ☐ Manfaat Kanser / Dialisis Buah Pinggang Keseluruhan Diagnosis Kali Pertama
  Lump Sum Cancer / Kidney Dialysis Benefit Upon First Diagnosis
- ☐ Bilik dan Penginapan yang Tidak Digunakan
  Unutilised Room and Board
- ☐ Rawatan Luar Kanser /Dialisis Buah Pinggang / Physiotherapy
  Outpatient Cancer / Kidney Dialysis / Physiotherapy
- ☐ Elaun Tunai Hospital Kerajaan
  Government Hospital Daily Cash Allowance

A. MAKLUMAT PESERTA / *PARTICIPANT'S DETAILS*

1 a. Nama Peserta / *Name of Participant* : _____
b. No. Kad Pengenalan/ *NRIC No.* : Baru/ *New* : _____ Lama/ *Old* : _____
c. Pekerjaan Semasa/ *Present Occupation* : _____
d. Nama Majikan & Alamat : _____
Name of Employer & Address : _____
2 Alamat Surat Menyurat Semasa : _____
Current Correspondence Address : _____
Poskod / *Postcode* : _____ Bandar / *Town* : _____
Negeri / *State* : _____
3 No. Telefon : a. Telefon Bimbit / *H/p* : _____ c. Pejabat / *Office* : _____
Telephone No. : b. Rumah / *House* : _____ d. Sambungan/ *Extention No.* : _____
4 E-Mel/ *E-Mail* : _____
5 Nama Bank/ *Name of Bank* : _____
6 No. Akaun Bank Peserta / Waris : Contoh: MBB0001. _____
Participant/ Beneficiary Bank Account No. : *E.g: MBB0001.*

** Sila lampirkan salinan muka hadapan buku bank / ** *Please enclose a copy of the front page of the saving book.*

B. MAKLUMAT ORANG YANG DILINDUNGI / PERSON COVERED'S *PERSONAL DETAILS*

1 Nama Orang yang dilindungi (jika berbeza dengan A) / *Name of Person covered (if differs from A)* : _____
2 No. Kad Pengenalan/ *NRIC No.* : Baru/ *New* : _____ Lama/ *Old* : _____
3 Alamat / *Address* : _____
Poskod / *Postcode* : _____ Bandar / *Town* : _____
Negeri / *State* : _____
4 E-Mel/ *E-Mail* : _____

C. MAKLUMAT WAKIL TAKAFUL / *AGENT'S INFORMATION*

1 Nama Wakil Takaful / Agent's Name : _____ Kod Wakil Takaful / *Agent's Code* : _____
2 No. Telefon / *Telephone No.* : a. Pejabat / *Office* : _____ b. Telefon Bimbit / *H/p* : _____
3 E-Mel/ *E-Mail* : _____

D. MAKLUMAT PENYAKIT/ *DIAGNOSIS INFORMATION*

(Sila isikan keterangan pada bahagian yang berkaitan sahaja) *Please complete the information in the relevant section*

1 a) Nama Hospital :
Hospital's Name

b) Tarikh Rawatan / Masuk Wad :
Date Of Treatment / Admission HH/*DD* BB/*MM* TT/*YY*

c) Tarikh Keluar Wad :
Date Of Discharge : HH/*DD* BB/*MM* TT/*YY*

d) Apakah diagnosis yang telah dimaklumkan kepada anda oleh doktor yang merawat ?
What was the diagnosis informed to you by the attending doctor ?

2 Sila nyatakan tarikh kali pertama/ *Please state the exact date (first date)* a) menerima rawatan/ *received treatment* : b) disahkan mendapat penyakit tersebut/ *diagnosed with the illness* :	HH/*DD* BB/*MM* TT/*YY* HH/*DD* BB/*MM* TT/*YY*
3 Sila nyatakan punca asal mendapatkan rawatan atau rujukan dari doktor tersebut *Please state the reason for seeking treatment or referral from the said doctoror*	
4 Jika diakibatkan oleh kemalangan, sila nyatakan seperti berikut: *If accidental case please state the following:* a) Tarikh kemalangan/ *Date of accident* : b) Bagaimana kemalangan berlaku : *Details description of the accident :* *Sila lampirkan salinan laporan polis/ laporan bedah siasat (jika ada) ** Please enclose a copy of police report or post mortem report (if any)*	HH/*DD* BB/*MM* TT/*YY* Masa: *Time:* _____ *am/pm*

E. LAIN LAIN TAKAFUL ATAU PAMPASAN / *OTHER TAKAFUL OR COMPENSATION*

Adakah Peserta membuat tuntutan atau pampasan dari syarikat insuran atau takaful yang lain? ☐ YA / *YES* ☐ TIDAK / *NO*
Is the Participant claiming the benefits under any other insurance companies or takaful operators?

Jika YA, sila berikan maklumat lanjut / *If YES, please give details :*

F. PENGAKUAN OLEH PENUNTUT / *DECLARATION BY THE CLAIMANT*

Saya / Kami _____ No. KP _____ pihak yang membuat tuntutan mengakui bahawa semua jawapan dan kenyataan yang tercatat di atas adalah lengkap dan benar sepanjang pengetahuan dan keyakinan Saya / Kami dan Saya / Kami tidak menyembunyikan atau merahsiakan butir-butir penting dari syarikat ini. Saya / Kami dengan ini menuntut manfaat Takaful dan lain-lain perolehan di bawah Pelan Takaful yang berkenaan daripada Takaful Ikhlas Family Berhad (selepas ini dirujuk sebagai pihak Syarikat) dan bersetuju bahawa kenyataan dan maklumat dari semua doktor yang memberi rawatan kepada peserta semasa hayatnya dan segala dokumen lain diberi untuk menyokong ini adalah menjadi bukti keilatannya. Selanjutnya, Saya / Kami bersetuju bahawa borang ini dan lain-lain dokumen tambahan yang diberikan mengenainya dan tindakan-tindakan siasatan dan pemeriksaan oleh pihak Syarikat tidak boleh ditaksir atau dianggap persetujuan menanggung tuntutan oleh pihak Syarikat dan tidak membuktikan ada sesuatu aqad Takaful yang berkuatkuasa mengenai diri yang diperkatakan atau sesuatu pelepasan sebarang hak atau pembelaan oleh pihak Syarikat. Saya / Kami dengan ini bersetuju membenarkan doktor-doktor atau lain-lain pihak atau hospital dan sebagainya memberi kepada pihak Syarikat penerangan atau maklumat yang mungkin diperlukan mengenai peserta.

I / We _____ NRIC _____ as the claimant hereby declare that all foregoing answers and information stated above are complete and true to the best of my / our knowledge and belief and I / We have not concealed any important details from this company. I / We hereby claim Takaful benefits and other acquisition under the relevant Takaful Plan from Takaful Ikhlas Family Berhad (hereinafter referred as the Company) and agree that all information disclosed by the doctors treating the participant during his lifetime and all documents provided to support this claim is proof of his / her disability. Further, I / We agree that this form and other additional related documents and investigations or examinations by the Company cannot be interpreted or assumed as admission of liability by the Company and is not proof of any agreement which take effect on the said person or discharged of any right or defense by the Company. I / We hereby give consent to doctors or related parties or hospitals etc. to disclose to the Company any explaination or information which is deemed necessary with regards to the participant.

Tandatangan Penuntut / Peserta
Signature of Claimant / Participant

Nama/ *Name* :
No. KP/ *NRIC No.* :
Tarikh/ *Date* :

Tandatangan Saksi
Signature of Witness

Nama/ *Name* :
No. KP/ *NRIC No.* :
Tarikh/ *Date* :
Hubungan/ *Relationship* :

G. LAPORAN PERUBATAN UNTUK DI ISI OLEH DOKTOR YANG MERAWAT (TUNTUTAN KEMASUKAN KE HOSPITAL / PEMBEDAHAN HARIAN SAHAJA)
MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING DOCTOR (FOR HOSPITALISATION CLAIM AND DAY CARE SURGERY ONLY)

Name of Hospital : _____ MRN NO : _____
Address : _____

Name of patient : _____

NRIC No. : _____

Date and Time of Admission : _____ _____ (hrs)
DD MM YY

Date and Time of Discharge : _____ _____ (hrs)
DD MM YY

Name of Referring Doctor and Address :

Admitting Doctor :

Attending Doctors :

Speciality :

1a. Diagnosis / ICD Coding :

1b. Cause and Pathology (if applicable) of the above diagnosis :

2a. When did patient first consult you for this condition?

2b. Was the patient previously treated for this condition?

2c. How long in your professional opinion has the condition existed?

_____
DD MM YY

4a. Please √ Nature of Treatment and Investigation:

- ☐ OPERATION
- ☐ DIETARY COUNSELLING
- ☐ X-RAY
- ☐ OTHERS, give details _____
- ☐ PHYSIOTHERAPY
- ☐ MEDICATIONS
- ☐ BLOOD TESTS

4b. If more than one procedure was involved, please state Type of Procedures performed:

	TYPE	DATE	NAME OF DOCTOR
i.			
ii.			
iii.			

4c. Other medical conditions present?

Since (dd mm yy) _____

Since (dd mm yy) _____

Since (dd mm yy) _____

3 Any possibility of a relapse?
☐ Yes ☐ No

5 Was the condition
☐ congenital ☐ nervous ☐ mental ☐ not related

6 Was the patient pregnant at the time of hospitalisation? (For Females Only)
☐ Yes ☐ No _____ Months

7 If the hospitalisation was due to accident, please indicate date / time of accident:

_____ _____ (hrs)
DD MM YY

8 Discharge / Follow-up instructions :

_____ _____ _____
Signature and Name of Attending Doctor | Hospital Stamp | Date