HOSPITALISATION CLAIM FORM / *BORANG TUNTUTAN KEMASUKAN HOSPITAL*

Note : Completion of this form is not an admission of claim / *Nota : Kelengkapan borang ini tidak bermakna tuntutan diluluskan*

Please answer all questions and attach the documents below / *Sila jawab semua soalan dan sertakan dokumen-dokumen dibawah*

- ☐ Original Bills, Itemized Detailed Bills and Original Receipts / *Bil asal, Bil terperinci dan Resit asal*
- ☐ Copy of NRIC / *Salinan Kad Pengenalan*
- ☐ Copy of lab test results/X-ray and radiological results / *Salinan keputusan makmal / X-ray dan keputusan radiologi*
- ☐ Copy of passport for overseas treatment / *Salinan pasport jika rawatan di luar negara*
- ☐ For admission claim, please submit Section E / *Untuk tuntutan kemasukan wad, sila kemukakan Seksyen E*

Please tick the Type of Claim / *Sila tanda jenis Tuntutan*

☐ Admission *Kemasukan Wad*
☐ Out-Patient Kidney Dialysis / Cancer *Rawatan Dialisis / Kanser Pesakit Luar*
☐ Government Hospital Cash Allowance *Elaun Tunai di Hospital Kerajaan*
☐ Pre/Post-Hospitalisation *Pra/Susulan Hospital*
☐ Emergency Out-patient Accidental Treatment *Rawatan Kecemasan Pesakit Luar Akibat Kemalangan*
☐ Others : *Lain-lain* : _____

SECTION A(I) : DETAILS OF LIFE ASSURED / COVERED PERSON / *SEKSYEN A(I) : MAKLUMAT ORANG YANG DIINSURANSKAN / DILINDUNGI*

Name of Patient
Nama Pesakit : _____

NRIC / Passport No.
No. KP / Pasport : _____

Date of Birth :
Tarikh Lahir : _____/_____/_____

Correspondence Address
Alamat Surat-Menyurat : _____

_____

_____

Occupation
Pekerjaan : _____

Name of Employer
Nama Majikan : _____

Address of Employer
Alamat Majikan : _____

_____

Name of Insurer / Takaful Operator
Nama Syarikat Insurans / Takaful : _____

Policy / Certificate No.
No. Polisi /Sijil : _____

Hanphone No.
No. Telefon Bimbit : _____

Office Tel No.
No. Tel Pejabat : _____

E-mail Address
Alamat E-mel : _____

SECTION A(II) PAYMENT DETAILS / *SEKSYEN A(II) MAKLUMAT BAYARAN*

Name of Account Holder
Nama Pemegang Akaun : _____

NRIC / Passport / Business Registration No.
No. KP / Pasport / Pendaftaran Syarikat : _____

Bank Name
Nama Bank : _____

Bank Account No.
No. Akaun Bank : _____

SECTION B(I) : DETAILS OF TREATMENT / *SEKSYEN B(I) : MAKLUMAT RAWATAN*

☐ Accident

Date of Accident
Tarikh kemalangan : _____/_____/_____

Time of Accident
Masa kemalangan : _____:_____ ☐ am ☐ pm

Circumstances and Place of Accident
Bagaimana kemalangan berlaku : _____

☐ Illness

Symptoms first appeared
Tarikh gejala bermula : _____/_____/_____

Date of Admission
Tarikh kemasukan wad : _____/_____/_____

Date of Discharge
T*arikh keluar wad* : _____/_____/_____

Date first treated
Tarikh pertama rawatan : _____/_____/_____

Name of first doctor seen
Nama doktor pertama merawat : _____

Name and address of clinic / hospital
Nama dan alamat klinik / hospital : _____

_____

SECTION B(II) : DETAILS OF REGULAR DOCTOR(S) / *SEKSYEN B(II) : MAKLUMAT DOKTOR BIASA*

Name of regular doctor(s)
Nama doktor yang biasa jumpa : _____

Name and address of clinic / hospital
Nama dan alamat klinik / hospital : _____

_____

_____

Tel No.
No. Tel : _____

SECTION B(III) : CLAIMS DETAILS / *SEKSYEN B(III) : MAKLUMAT TUNTUTAN*				
No *No*	Invoice No *No Invois*	Invoice Date *Tarikh Invois*	Receipt No *No Resit*	Amount *Jumlah*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

SECTION C : OTHER INSURANCE / TAKAFUL COVERAGE / *SEKSYEN C : PERLINDUNGAN INSURAN / TAKAFUL LAIN*				
Item *Bil*	Insurance / Takaful Company Name *Nama Syarikat Insuran / Takaful*	Policy / Certificate No. *No. Polisi / Sijil*	Type of Policy / Certificate *Jenis Polisi / Sijil*	Coverage Amount *Jumlah Perlindungan*
1				
2				
3				

SECTION D : DECLARATION AND AUTHORIZATION / *SEKSYEN D : PENGISYITIHARAN DAN PEMBERIAN KUASA*

I hereby declare that the answers given above are true and complete to the best of my knowledge. I agree that in the event 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 Assured/Covered Person's health and condition, Integrated Health Plans (Malaysia) Sdn. Bhd. shall absolutely forfeit my/the Life Assured/Covered Person's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

And, I hereby irrevocably authorize any organisation, institution, or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal and billing information or details of related accident/injury, to disclose to Integrated Health Plans (Malaysia) Sdn. Bhd. or its representative such information. I agree that Integrated Health Plans (Malaysia) Sdn. Bhd. or its representative may use or disclose any of the information collected or held to relevant third parties (within or outside Malaysia, including reinsurers, medical examiners, claims investigators and industry associations/federations etc.) in relation to this claim. This authorization shall bind my/the Life Assured/Covered Person's successors and assigns and remain valid notwithstanding my/the Life Assured/Covered Person incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original.

Saya dengan ini mengisytiharkan bahawa maklumat yang diberi dalam borang tuntutan ini adalah benar dan lengkap berdasarkan pengetahuan saya. Saya bersetuju sekiranya saya membuat, atau pada masa lalu membuat pernyataan yang salah atau tidak benar dan/atau tidak mendedahkan atau menyembunyikan sebarang fakta penting berkenaan kesihatan dan keadaan saya/hayat yang diinsuranskan/dilindungi, Integrated Health Plans (Malaysia) Sdn. Bhd. akan secara mutlak berhak menarik balik hak saya/hayat yang diinsuranskan/dilindungi untuk mendapat pampasan dan seterusnya mendapatkan hak untuk menuntut semula sebarang jumlah yang telah dibayar sebelum ini.

Dan saya, dengan ini memberi kebenaran mutlak kepada sebarang organisasi, institusi atau individu yang mempunyai sebarang rekod atau pengetahuan atau sejarah perubatan atau rawatan atau nasihat perubatan yang telah atau mungkin selepas ini dimaklumkan, maklumat peribadi atau bil atau sebarang maklumat mengenai kemalangan/kecederaan yang berkaitan untuk didedahkan kepada Integrated Health Plans (Malaysia) Sdn. Bhd. atau wakilnya tentang maklumat tersebut. Saya bersetuju

bahawa Integrated Health Plans (Malaysia) Sdn. Bhd. atau wakilnya boleh menggunakan atau mendedahkan maklumat yang telah dikumpul atau disimpan kepada pihak ketiga yang berkaitan (di dalam atau di luar Malaysia, termasuk syarikat insurans semula, pemeriksa perubatan, penyiasat tuntutan dan persatuan/pertubuhan dan lain lain) yang berkaitan dengan tuntutan ini. Kebenaran ini mengikat waris dan penerima serah hak dan akan kekal sah, tanpa mengira kematian atau ketidakupayaan saya/hayat yang diinsuranskan/dilindungi dari segi undang-undang. Salinan kebenaran ini dianggap sama sah dan berkesan seperti kebenaran asal.

Signature of Policy / Certificate Owner
Tandatangan Pemilik Polisi / Sijil

Full Name :
Nama Penuh
NRIC No. :
No. KP
Tel No. :
No. Tel

Signature of Life Assured/Covered Person
Tandatangan Orang Yang Diinsuranskan/Dilindungi

Full Name :
Nama Penuh
NRIC No. :
No. KP
Tel No. :
No. Tel

Signature of Witness
Tandatangan Saksi

Full Name :
Nama Penuh
NRIC No. :
No. KP
Tel No. :
No. Tel

Date
Tarikh

Company's Stamp (For Group Policy/Certificate)
Cop Syarikat (Untuk Insurans/Sijil Berkelompok)

Integrated Health Plans (Malaysia) Sdn Bhd (200601008284 (728033-T))
(Formerly Known as Corporate Outsource Services Sdn Bhd - COSSB)
Tel : 1300880100

Kuala Lumpur
B03-A-13A, Level 13A, Menara Pacific 3
Jalan Bangsar, KL Eco City,
592OO Kuala Lumpur

Johor Bahru
Suite 23A.08, Level 23A, Johor Bahru City Square
Office Tower, Jalan Wong Ah Fook,
80000 Johor Bahru, Johor

Penang
1-3-12, 1-3-12A, 1-3-14 & 1-3-15,
Krystal Point 2 Corporate Park, Jalan Lebuh Bukit Kecil
6, Bayan Lepas 11900, Penang.

SECTION E : ATTENDING PHYSICIAN'S STATEMENT / *SEKSYEN E : LAPORAN PERUBATAN DOKTOR*

NAME OF PATIENT : _____ **NRIC / PASSPORT NO :** _____

1. Date of Admission : _____ 2. Time of admission : _____ am / pm
3. Date of Discharge : _____ 4. Time of discharge : _____ am / pm
5. First consultation date with you : _____
6. Name of referral clinic/hospital : _____ 7. Name of referral doctor : _____
8. If due to accident :
   (a) Date of accident : _____ (b) Time of accident : _____ am / pm
   (c) Name of clinic/hospital first treated : _____ (d) Date first treated : _____
   (e) Circumstances of accident : _____
9. Symptoms presented : _____
10. Duration of symptoms : _____ 11. Date symptoms first appeared : _____
12. Final Diagnosis : _____
13. Date first diagnosed : _____ 14. MMA Code(s): _____
15. Name of clinic/hospital first diagnosed : _____ 16. Name of doctor first diagnosed : _____
17. Underlying cause of diagnosis : _____
18. a) Has the patient ever had any of the following illness/condition ?

(i) Hyperlipidemia	☐	Yes	☐	No	onset: _____	(i) Congenital	☐	Yes	☐ No
(ii) Hypertension	☐	Yes	☐	No	onset: _____	(ii) Hereditary	☐	Yes	☐ No
(iii) Diabetes	☐	Yes	☐	No	onset: _____	(iii) Psychiatric / Mental Disorder	☐	Yes	☐ No
(iv) Heart disease	☐	Yes	☐	No	onset: _____	(iv) Pregnancy related / Fertility	☐	Yes	☐ No
(v) Stroke/TIA/Epilepsy	☐	Yes	☐	No	onset: _____	(v) Self-inflicted injury	☐	Yes	☐ No
(vi) SLE / Rheumatoid Arthritis	☐	Yes	☐	No	onset: _____	(vi) Cosmetic reason	☐	Yes	☐ No
(vii) Cancer / Tumour	☐	Yes	☐	No	onset: _____	(vii) Dental care	☐	Yes	☐ No
(viii)Others: _____	☐	Yes	☐	No	onset: _____	(viii) AIDS / STD	☐	Yes	☐ No

18. b) If any condition above is Yes, please provide further details : _____
19. Result of investigations (e.g.MRI, CT-Scan, Ultrasound,Lab tests) _____
20. Procedure(s)/Treatment done _____
21. Date of surgery(ies) : _____ 22. MMA Code(s) : _____
23. Can condition/procedure be managed under an out-patient arrangement? ☐ Yes ☐ No
    If no, please explain reason for admission _____
24. Any consultation / treatment for this illness or other disorders in this hospital or any other facilities ? ☐ Yes ☐ No
    If yes, please provide details below :

Date	Disease / Disorder	Details of Treatment / Admission	Doctor / Hospital / Clinic

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 of his/her condition :

Doctor's Signature : _____

Name : _____

Date : _____

_____
Doctor's Clinic/Hospital Stamp

Contact No. _____