GROUP CLAIMS CLAIMANT STATEMENT FORM

GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

Type of Claims

Note: Please tick (✓) the relevant claims type & refer to Claims Checklist for list of required supporting documents for submission

☐ Hospitalisation Benefit (HB) ☐ Total Permanent Disability ☐ Terminal Illness ☐ Accidental Death

☐ Critical Illness ☐ Partial Permanent Disability ☐ AIR Weekly Indemnity ☐ Death ☐ Khairat

Section A: Details of Person Covered/ Deceased

Contract No	TGTW000847 (GTL/DEATH) OR TGWH000542 (GHS/HOSPITALISATION)			
Name of Contract Holder	INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA (IIUM)			
Name of person Covered	TO BE FILLED BY THE CLAIMANT (TBFBTC)			
MyKad No. OR Other ID No.	TO BE FILLED BY THE CLAIMANT (TBFBTC)			
Contact Details	Phone	Mobile: TBFBTC	House:	Office:
	Fax No.		Email	TBFBTC
Current Corresponding Address	TBFBTC Postcode: TBFBTC Town: TBFBTC State: TBFBTC			
Current Occupation & Job Nature	STUDENT			

Section B: Details of Claimant

Relationship with Person Covered	☐ Own	☐ Spouse	☐ Child	☐ Parent
	☐ Employer	☐ Contract Holder	☐ Others *(Please specify:)*	
Name	TBFBTC			
MyKad No. OR Other ID No.	TBFBTC		Benefit Sum Assured *(Applicable for Employers only)*	RM
Contact Details	Phone	Mobile: TBFBTC	House:	Office:
	Fax No.		Email	TBFBTC
Current Corresponding Address	TBFBTC Postcode: TBFBTC Town: TBFBTC State: TBFBTC			
Bank Account Details *(Current or Savings Account)*	Bank Name	TBFBTC		
	Bank Account Holder Name	TBFBTC		
	Account Type TBFBTC	☐ Current	☐ Savings	
	Account Number	TBFBTC ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐		
	Swift Code (if applicable)	☐☐☐☐☐☐☐☐☐☐☐		

Section C: Details of Claims

Claim Type : Death/ Accidental Death /Funeral Expanses/ Khairat Claim

Date of Death *(dd/mm/yyyy)*		**Last Working Date (If employed)**	
Any Post Mortem Done?	☐ **Yes** *(Please provide copy of the report)* ☐ **No**		

Claim Type : Hospitalisation /Critical Illness/ Terminal illness /AIR Weekly Indemnity Claim

Date of Admission *(dd/mm/yyyy)*		**Date of Discharge** *(dd/mm/yyyy)*	
Admitted Hospital			
Diagnosis			
First Date of Signs & Symptom for the Diagnosis *(dd/mm/yyyy)*		**Medical Certificate (MC) Dates** *(dd/mm/yyyy)*	
Date of Accident *(dd/mm/yyyy)*		**Place of accident**	

Claim Type : Total / Partial Permanent Disability Claim

Date of Admission *(dd/mm/yyyy)*		**Date of Discharge** *(dd/mm/yyyy)*	
Diagnosis			
First Date of Signs & Symptom for the Diagnosis *(dd/mm/yyyy)*		**Medical Certificate (MC) Dates** *(dd/mm/yyyy)*	
Date of MC/ Prolonged Illness Leave	**Start Date** *(dd/mm/yyyy):*	**End Date** *(dd/mm/yyyy):*	
Current Salary Status	☐ **Full Salary**	☐ **Half Salary**	☐ **No Salary**
Last Drawn Monthly Basic Salary	**Paid Date** *(dd/mm/yyyy*	**Salary Amount** **RM**	
Last Working Date *(dd/mm/yyyy)*		**Date of Resignation /Medically Boarded out / Early Retirement (if any)**	

DECLARATION

I do solemnly and sincerely declare that I am the nominee/administrator/beneficiary for the Takaful benefit of the deceased and further declare as follows:-

1. That the foregoing answers and statements on the Deceased are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
2. That any difference, if any, in respect of the details contained in the enclosed supporting document and the information presented to Etiqa Takaful Berhad(Etiqa) in this form refers to the same person. I understand and agree that Etiqa has the sole discretion to reject this application if the information given is false or insufficient.
3. That the original certificate whether or not enclosed therein (if any), due to loss or mutilated, belongs to the deceased.
4. And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish Etiqa Takaful Berhad or its representative any information that may be required concerning my health conditions, for settlement of this claim. I agree that Etiqa Takaful Berhad or its representative may use or disclose any of the information collected or held to third parties such as reinsurers, medical examiner or medical consultant, claims investigator and etc. within or outside Malaysia for the purpose of processing the claim. I agree that a photocopy of this authorization shall be considered as effective and valid as original.
5. I, agree, consent and allow Etiqa Family Takaful Berhad (hereinafter called "Etiqa Takaful") to process my personal data (including sensitive personal data) ('Personal Data') with the intention of processing this Claim Form, in compliance with the provisions of the Personal Data Protection Act 2010.
6. I, understand and agree that any Personal Data collected or held by Etiqa Takaful contained in this Claim Form may be held, used, processed and disclosed by Etiqa Takaful to individuals and/or organizations related to and associated with Etiqa Takaful or any selected third party (within or outside Malaysia, including medical institutions, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this Claim Form and providing subsequent service related to it and to communicate with me for such purposes.
7. I agree that a copy of documents submitted shall be as valid as the original. I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.

SIGNATURE OF THE CLAIMANT

Date TBFBTS **Date:**