PERSONAL ACCIDENT & HEALTH CLAIM FORM

- **Issuance of this form is not to be construed as an admission of liability on the part of the Company.**
- **Each question must be answered fully and completely. If insufficient space is provided for your answers, please continue on a separate sheet.**

DOCUMENTATION CHECKLIST (where appropriate)

☐ Dully completed, signed and witnessed claim form	☐ Death Certificate & Burial Permit for Death Claim
☐ Medical Report (where required)	☐ Discharge Note
☐ Original Medical Bills	☐ Lab Reports
☐ Original Medical Certificate	☐ Any other physician/surgeon/consultant report
☐ X-Ray Reports for PA claims	☐ Photographs of claimant (if necessary)
☐ Letter of Employment	☐ Copy of Beneficiary's I.C.
☐ Confirmation of Employment or current salary slip/s prior to the loss (or injury)	☐ Copy of OKU Card
☐ Police report for Motor Vehicle Accident	

SECTION A:

PARTICULARS OF INSURANCE

Policy No :	Renewal Cert No: (if applicable)
Policy Period: From To	

INSURED'S PARTICULARS

Name	NRIC No:
Address	
Business / Occupation	Tel. No & Contact Person:
Claimant's Name(if claimant is a dependant / member of a group policy)	
Claimant's Occupation & Nature of Work	Date of Employment:
Is claimant entitled to any claim against Workmen's Compensation benefits / SOCSO / Medical benefits from any other insurer?	☐ YES ☐ NO
If yes, please state Insurance Company and policy details	

TUNE PROTECT MALAYSIA
(Tune Insurance Malaysia Berhad (30686-K))
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ACCIDENT CLAIM

Date & Time of Accident.	Place of Accident.
Describe briefly how it happened	Describe briefly the injuries sustained
Please give name of persons who witnessed the accident (if any)	

GST DETAILS

Are you or will you be a registered person under the Malaysian Goods and Services Tax (GST) at the commencement date of this policy	☐ YES	☐ NO
If yes, please provide the following:- (i) GST Identification No (ii) Date of registration	: _____ : _____	
Is the above policy for:- (i) Personal (including sole proprietorship) (ii) Business	☐ YES ☐ YES	☐ NO ☐ NO
Is the input tax incurred by you on the medical or personal accident policy premium blocked from claims under Regulation 36 of the GST Regulations 2014? (Applicable for Medical and Personal Accident only)	☐ YES	☐ NO

I/we acknowledge that I/we have accessed and/or read the Privacy Notice of TIMB (available at all TIMB branch customer service counters and/or TIMB website) and agree to the processing of my/our personal data in the manner specified therein. I/we also consent to the collection, further processing and disclosure of my/our sensitive details herein for the purpose of processing claims and making the related payments.

DECLARATION

I/We hereby declare that the above statements and particulars are correct and complete in every respect and I/We have not concealed, misrepresented or misstated any material fact.

I/We agree that if such statements and particulars are written by any other person, such person shall be deemed to have my/our Agent for the purpose of filling in this form and his statement shall be binding upon me/us

I/We hereby acknowledge and understood the contents of the Personal Data Protection Act 2010 and agree to give my fullest co-operation to Tune Insurance Malaysia Berhad or its representative in relation to this claim

....

Name **Signature**

Date: ..... /..... / .....

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SECTION B
MEDICAL REPORT

To Attending Doctor,

PATIENT'S AUTHORISATION: I hereby give my consent for you to disclose all information requested by this medical to the report Insurance company.

Signature of Patient _____ Date _____

CERTIFICATE OF MEDICAL ATTENDANT

A legally qualified and registered medical practitioner at the must complete this medical certificate for claims exceeding RM200 and for hospitalisation claims only.

1. Date of accident:	2. Date and Time of first consultation:
3. Please provide an account of the accident	4. Please give full details of injuries
5. Were there any external and visible injuries or wound as a result of this accident? ☐ YES ☐ NO	6. Please supply details of treatment given
7. Are injuries consistent with the circumstances of the accident as described to you? ☐ YES ☐ NO	8. Have you any reason to suspect patient was not sober at the time of accident? ☐ YES ☐ NO
9. How long have you known the patient?	10. Has the patient consulted any other medical practitioner: ☐ YES ☐ NO
11. What is the present condition of the injuries?	12. Please list the dates of patient's visit to you since the accident
13. Is there any previous medical history or disablement which might have contributed to the occurrence of the accident or which may retard/prolong recovery? ☐ YES ☐ NO If yes, please provide details	

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FRACTURE

	Type of Fracture	Treatment/Management
	☐Close Fracture ☐Open Fracture ☐Others	
	☐Open Fracture ☐Open Fracture ☐Others	
	☐Open Fracture ☐Open Fracture ☐Others	

AMPUTATION - For Amputation / Loss of Limbs

14. Which part of limb was amputated?	
15. Amputation at what level ☐ Proximal ☐Middle ☐Distal	
16.Is physiotherapy necessary? ☐ YES ☐ NO If yes, please furnish us the dates the patient was on physiotherapy.	17.Is there any limitation of movement on any joint at the last treatment date ? ☐ YES ☐ NO 18. Was X-Ray taken ? ☐ YES ☐ NO

FOR ILLNESS

1.Diagnosis of illness or injury	
2.When did patient consult you for the condition?	
3.Was the patient referred to you by any other doctor? If yes, please give particulars of the doctor	☐ YES ☐ NO
4.How long was the condition existing before the first symptoms appeared ?	
5.How long has the patient been troubled by symptoms prior to consulting you?	
6.Has patient ever had the same or similar related conditions or symptoms before? If yes, please state when and describe	☐ YES ☐ NO
7.Has the patient previously received treatment for the above symptoms? If yes, please give details.	☐ YES ☐ NO

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8.Have any investigations, tests or procedures been performed? If yes, please furnish copy of the results	☐ YES	☐ NO
9.Nature of medical treatment given		
10.Is illness arising out of pregnancy, childbirth or infertility?	☐YES	☐NO
12.How long do you feel the symptoms had lasted?		
13.Has any surgical operation been performed? If yes ,please state when and type of operation	☐YES	☐NO
14.Any possibility of having relapse?	☐YES	☐ NO

Attending Doctor's Statement: I hereby certify that I have examined the above patient and that the facts as set forth are true and to the best of my knowledge

Signature of Doctor :----------

Name :----------

Qualification :----------

Address :----------

Date :----------

DEFINITIONS

- Temporary Total Disablement: The claimant /patient should be incapacitated from attending any part of his/her occupation.
- Temporary Partial Disablement: The claimant/patient should be incapacitated in the sense that he is unable to attend to a substantial and essential part of his occupation.

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