Claim Form

Cancer LoanBreak

TOKIO MARINE
INSURANCE GROUP

Note: All sections must be completed and returned to Tokio Marine Insurans (M) Bhd. together with the relevant documentation within 30 days from date of prescription of Chemotherapy or Radiotherapy treatment.

Part 1: To be completed by Insured

i. Name: _____

Insured NRIC: _____ Date of Birth: _____ Sex: _____

ii. Have your loan under this product been fully redeemed or refinanced with your financial institution?

☐ Yes ☐ No If yes, please state the loan redemption / refinancing date. D D M M Y Y Y Y

Loan Account No.: _____

Note : If your loan has been fully redeemed or refinanced before the confirmation date of terminal cancer or chemotherapy/ radiotherapy is required, then you will not be eligible for any claim.

iii. Symptoms First Appeared on: D D M M Y Y Y Y Date of diagnosis on: D D M M Y Y Y Y

Declaration and Authorisation To Physician, Clinic or Hospital

By signing this Claim Form:

i) I hereby declare that the answers provided above are true and complete to the best of my/our knowledge and belief.

ii) I hereby irrevocably authorize any organization, 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 information or details of related disability, to fully disclose to TOKIO MARINE INSURANS (Malaysia) Berhad or its authorized representative such information in relation to this claim.

This authorization is irrevocable and a photocopy of it will have the same effect and validity as the original.

Acknowledgement & Declaration

Personal Data Protection Act 2010 (PDPA) Notice

i. I/We acknowledge and consent that the personal data, including any sensitive personal data, collected herein be used and processed for the purpose of this claim and be disclosed to reinsurers; individuals or organizations associated with Tokio Marine Group, or involve in any claim settlement; or PIAM/ISM;

ii. I/We confirm that I/we have obtained the consent of the person(s) and/or nominee(s) named herein, where applicable, and that he/she/they has/have authorized me/us to disclose their personal data and to give consent on their behalf for the above collection, use, process and disclosure;

iii. I/We acknowledge that I/we am/are obligated to provide the above personal data failing which my/our claim could not be processed and that I/we am/are entitled to obtain access to, request for correction of or limit the processing of my/our personal data; and

iv. I/We acknowledge the detail Privacy Policy Statement, governing the above, posted at www.tokiomarine.com.my, that a Privacy Notice informing me of the above would be sent together with my/our policy, and that I/we could also make enquiry with regard to the PDPA through email send to enquiry@tokiomarine.com.my.

Declaration

I/We understand that it is my/our duty to take reasonable care not to make a misrepresentation in answering the questions in this Claim Form and I/we hereby declare that I/we have fully and accurately answered the questions above.

Documents To Be Attached Herewith This Form

☐ Copy of proof of identification

☐ Copy of the histopathology/pathological report/any evidence of malignancy

☐ Proof of Chemotherapy or Radiotherapy treatment has commenced

_____

Signature of Insured

Name :

NRIC :

Date :

Part 2: Medical Report (To be completed by Attending Physician / Surgeon)

1. Name of Patient: _____ NRIC: _____

2. Has patient been diagnosed with cancer? ☐ Yes ☐ No

3. a) Please state symptoms presented and date symptoms first appeared:

Symptoms	Duration of Symptoms	Date Symptoms First Started

b) Date when Patient first became aware of this illness: |_|_|_|_|_|_|_|_| D D M M Y Y Y Y

c) Final Diagnosis: _____

d) Stage/Grade of Cancer: _____ e) Date First Diagnosed: |_|_|_|_|_|_|_|_| D D M M Y Y Y Y

4. Please provide the patient with a copy of the biopsy reports, cytology or pathology report, or any other reports confirming on the diagnosed cancer. (Compulsory requirement)

5. Patient first consulted you for this condition on: |_|_|_|_|_|_|_|_| D D M M Y Y Y Y

6. Was the patient referred to you by another physician? ☐ No ☐ Yes, Physicians name and address

_____

7. Does the patient need to undergo any Chemotherapy/Radiotherapy as part of the treatment plan?
   If Yes; i) Date of first Chemotherapy/Radiotherapy rendered : |_|_|_|_|_|_|_|_| D D M M Y Y Y Y
   ii) Confirmation date of Chemotherapy/Radiotherapy is required : |_|_|_|_|_|_|_|_| D D M M Y Y Y Y

8. Has the Patient ever had any malignant, pre-malignant or other related conditions or risk factor or undergone any form of Chemotherapy/Radiotherapy previously?
   If Yes, please provide details, including date of diagnosis name & address of doctor/clinic and source of information

_____

9. In your professional opinion, what is the life expectancy for the patient?
   ☐ Less than 6 months ☐ More than 6 months ☐ Unknown

   If less than 6 months, please justify: _____

10. Does any of the immediate family member of the patient has history of being diagnosed with cancer? ☐ Yes ☐ No
    If Yes, please provide details as below.

Relationship to the Patient	Type of Cancer	Age on Onset

11. Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) ?
    ☐ Yes ☐ No If Yes, please provide the date of diagnosis for HIV/AIDS: |_|_|_|_|_|_|_|_| D D M M Y Y Y Y

Declaration

I hereby certify that I have personally examined and treated the Patient for his/her illness described above and that the facts as stated above represent my medical opinion of his/her condition.

Date _____ Name & Signature of Attending Doctor _____ Doctor / Hospital Stamp _____

Registration Form

E-Payment

TOKIO MARINE
INSURANCE GROUP

Section A: Personal Details

Account Holder Name: _____

Account Holder Address: _____

Business Registration No. (Non-individual): _____

NRIC No./ID No./Passport No. (Individual): _____

Telephone No: _____

Handphone No: _____

Contact Person 1: _____

Email: _____

Contact Person 2: _____

Email: _____

Bank Name _____

Bank Code _____

Bank Account Number (please ignore all dashes: '-')

Account Type ☐ Current Account ☐ Saving Account

Other Info ☐ Individual Account ☐ Joint Account

☐ Others
(Support With Relevant Documents)

NRIC No./ID No./Passport No. (individual) for the 1st name

Section B: Declaration

I/We hereby authorize Tokio Marine Insurans (Malaysia) Berhad (TMIM) to credit all monies due to me/us to my/our bank account indicated above by way of Giro Fund Transfer/Rentas and confirm that:

1. I/We hereby declare that the above is my personal account/our company account, and the information given is true and accurate to the best of my/our knowledge and record and I confirm that the account number written under this E-payment form is correct.
2. I/We shall indemnify TMIM for any loss, damage or claims incurred in whatsoever manner as a consequence of acting on such instruction.
3. I/We hereby give my consent to TMIM to disclose my Personal Data to TMIM's service providers and/or financial institutions for the purpose of effecting and administrating the electronic payments (Personal Data includes name, personal identification number, contact details and any other details not specifically mentioned herein).
4. I/We understand that the supply of my Personal Data herein is voluntary and it is necessary for TMIM to process my Personal Data for effecting and administrating the electronic payments to me.

Notice:

Any future changes on the customer personal data, customer are required to write-in to us on the changes. Therefore, kindly provide the email address for the customer to notify the Person In Charge (PIC) to change his/her personal details and email to "letusknow@tokiomarine.com.my".

Authorised Signatory

Name:

Position:

Date:

***Company/Agency Signatory & Stamp**

**Select where applicable*

FOR OFFICE USE ONLY

To be completed by relevant department:

Client Code: _____

Date: _____ (D D M M Y Y Y Y)

Requestor's Name & Signature/Stamp: _____

Requestor's Reporting Supervisor Name & Signature/Stamp: _____

Date received: _____ (D D M M Y Y Y Y)

Created by: _____ Date: _____

Verified by: _____ Date: _____

* Mandatory to proceed with payment processing on change request: This must be verified with a follow-up call with Payee / Counterpart with Contact details provided

*Call-Back Verification Date _____ (D D M M Y Y Y Y)

* Verified by payee/counterpart on record with TMIM ☐ Yes ☐ No *Supported with email confirmation on call-back verification*

*Verifier Name & Signature _____

* Reporting Supervisor/HOD Name & Signature _____

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