TOKIO MARINE
INSURANCE GROUP

Claim Form

Medical Insurance

Information collected in this claim form shall be used in connection with the Company's purposes and course of business only. This form must be completed to avoid any delay in the settlement of claim.

Part 1: Insured Person Information

Policy Number: _____

Name of Insured Person: _____

NRIC/Passport No: _____ Telephone No: _____

Company Name
(if Insured is covered under a Group Policy): _____

Part 2: Patient Information (If other than Insured)

Name of Patient: _____ Gender: ☐ Male ☐ Female

NRIC/ Passport/ BC: _____ Date of Birth: D D M M Y Y Y Y

Relationship to Insured Person: _____

Part 3: Claim Details

Important Note:

- **Certified true diagnosis is required for all claims amounting to RM500 and below.**
- **Detail itemized bill is required for incurred amount above RM100 in a single receipt / visitation.**
- For Death Claim, a copy of Death Certificate is required.
- For Hospital Cash Allowance Claim, *discharge summary/medical report* of admission at Government Hospital is required.
- For Group Policy only - Maternity and Outpatient claim (GP/SP/Optical/Dental (not due to accidental) and Medical Examination) kindly complete the **Outpatient Reimbursement Claim Form**.

Please (✓) Type of Claim and answer accordingly

☐ Pre & Post Hospitalisation / Follow up for Outpatient Accidental Injury/Dental Injury Treatment

☐ Outpatient Cancer Treatment / Outpatient Kidney Dialysis Treatment Claim
Is this the first treatment or a continuous treatment? ☐ First treatment ☐ Continuous treatment

☐ Emergency Sickness Treatment
Date of Visit D D M M Y Y Y Y (b) Time of Visit H H M M ☐ am ☐ pm

☐ New Claim - Hospitalisation / Daycare Surgery / Outpatient Accident Injury / Dental Injury / Hospital Cash Allowance / Death Claim
Is this new claim due to Accident? ☐ Yes (Please complete Q1) ☐ No (Please complete Q2)

Q1. Accident Details

a) Date D D M M Y Y Y Y Time H H M M

b) Date of first consultation with doctor/hospital: D D M M Y Y Y Y

Clinic / Hospital Name _____

c) Please describe briefly how the Accident happened and extent of injury (ies) sustained?

_____

_____

Q2. Illness Details

a) First treatment sought date D D M M Y Y Y Y

b) i. Name of first Doctor consulted _____

ii. Name & Address of Clinic /Hospital:

_____

_____

Tokio Marine Insurans (Malaysia) Berhad
198601000381 (149520-U)
Level 20, Menara Hap Seng 3, Plaza Hap Seng, No. 1, Jalan P. Ramlee, 50250 Kuala Lumpur, Malaysia.
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Part 4: Payee Information

Claim Payment in Favor of? (Please specify name of payee)

☐ Policy Owner: _____

☐ Insured Person / Claimant: _____

☐ Others (Please specify relationship): _____

Note: For first time payee (applicable to individual payee only), kindly complete the E-Payment Form to facilitate payment via E-Banking.

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 (M) BHD 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 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.

_____

Signature of Patient
(Note: Insured should sign if patient is a child below 18 years of age)

Name:

NRIC:

Date:

_____

Signature of Policy Owner

Name:

Date:

Company Stamp:

(Company Stamp is compulsory for Group Policy)

Medical Report

(To be completed by Attending Physician / Surgeon)

TOKIO MARINE INSURANCE GROUP

1. a. Patient's Name: _____ b. Age: _____

   c. NRIC: _____ d. Gender: ☐ Male ☐ Female

2. This report is regarding of patient's: ☐ Admission ☐ Day Care Surgery ☐ Others, please specify: _____

3. Admission Date and Time: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y) (Time) _____ ☐ am ☐ pm

4. Discharge Date and Time: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y) (Time) _____ ☐ am ☐ pm

5. a. Symptoms / Conditions requiring admission: _____

   b. Patient's BP / Temp. / Pulse: _____

   c. How long is patient aware of the condition: _____

   d. Date symptoms first appeared: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y)

   e. Date first consulted: ☐☐☐☐☐☐☐☐ (D D M M Y Y Y Y)

6. a. Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No

   Name and Address of doctors previously consulted by the patient for the condition:

   _____

   _____

   b. Was this patient referred to you? If yes, please provide details below:

   _____

   c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:

   _____

   d. Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
   If no, please provide reasons of admission:

   _____

7. a. Final Diagnosis: _____

   b. Cause and pathology underlying the present diagnosis: _____

   _____

   c. Any possibility of relapse: ☐ Yes ☐ No
   Is follow up required? ☐ Yes ☐ No

8. Is the illness / condition related to (please tick (✓) if YES):

   ☐ Pregnancy / Childbirth / Infertility / Caesarean Section / Miscarriage or any complications arising therefrom
   ☐ Congenital / Hereditary Diseases
   ☐ Influence of Drugs / Alcohol
   ☐ Nervous / Mental / Emotional / Sleeping Disorder
   ☐ Cosmetic Reason / Dental Care / Refractive Errors Correction
   ☐ AIDS / STD / VD / HIV
   ☐ Self-inflicted Injuries / Violation of Laws / Strike / Riots
   ☐ None of the above

   Please provide details:

   _____

   _____

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9. a. Treatment given / investigation done (please supply copy of all investigation results):

_____

_____

b. Surgical procedures performed: _____

c. MMA code / PHFSR code: _____

d. Date of surgery / procedure: D D M M Y Y Y Y

10. Any other medical / surgical conditions present: ☐ Yes, details below ☐ No

a. _____

b. _____

11. a. Was the patient pregnant at the time of hospitalisation? (For Female only) ☐ Yes, _____ months ☐ No

b. Was the illness caused directly or indirectly by pregnancy/child birth/caesarian section/ abortion miscarriage and all complications arising therefrom? ☐ Yes, details below ☐ No

_____

12. a. If hospitalisation was due to injury, please describe circumstances and cause of injury: ☐ Yes, details below ☐ No

_____

b. Please indicate date/time of accident: D D M M Y Y Y Y (Time) _____ ☐ am ☐ pm

13. In the case of DEATH, please advise Date/Time and Cause of death:

_____

_____

14. I hereby certify that I have personally examined and treated the Patient for his/her injury/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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