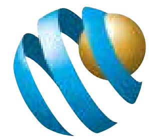


Claim Form

Overseas Travel Accident Insurance

I hereby make a claim for insurance benefits by confirming the accuracy of the contents hereof and also by agreeing to the matters mentioned below. A photocopy of this claim form shall be considered as effective and valid as the original.

In Case Medical Investigation Is Required.
I hereby authorize any hospital, physician, or other person who has attended or examined the insured, to furnish to the TOKIO MARINE INSURANS (MALAYSIA) BERHAD or its authorized representative (hereinafter called "The Company"), any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment as well as copies of all hospital or medical records.

A. Particulars of Claimant*

Claimant: ______________________ Gender: ☐ Male ☐ Female Age: ___

Address: ______________________

Policy/Certificate No.: ______________________ Insurance Period: D D M M Y Y Y Y to D D M M Y Y Y Y
(Please attach copy)

B. Details of Claimant**

Kind of Benefits Claimed (Please indicate "✔"):

☐ Sickness Medical Expenses
Sum Insured ______________________

☐ Injury Medical Expenses
Sum Insured ______________________

Date of Sickness/Injury : D D M M Y Y Y Y

Diagnosis of Sickness : ______________________

Place of Accident : ______________________

Circumstances : ______________________

*Police Report *(Please attach if available)*

I hereby declare that the above information are true and correct in every aspect and agree that if I have made any false or untrue statement, any concealment, suppression, mis-statement or omission of material fact or if the claim is exaggerated in any manner, my right to the compensation shall be absolutely forfeited.

Authorization To Physician, Hospital Or Clinic To Release Information

I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I have been observed or treated, to give full particulars about my health including my whole medical history to Tokio Marine Insurans (Malaysia) Berhad.

I further authorize any insurance company and its authorized representatives to release all information and documents pertaining to my policies including all previous and current claim details to Tokio Marine Insurans (Malaysia) Berhad.

A photocopy of this authorization shall have the full effect of the original authorization.

____
Signature of Insured/Claimant

Name: ______________________

NRIC: ______________ Date: ______________

____
Company Stamp (if applicable)

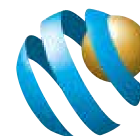
Designation: ______________________

* If the claimant is a child who is a minor, we would like his/her father/mother to make a claim as claimant on behalf.

** Following cases are excluded from the insurance coverage:
Chronic Disease, Dental Treatment, Pregnancy, Sickness Occurring Prior to the Inception Date of Insurance, Medical Check-Up.

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.
T: (03) 2027 8200 / 2789 8800 F: (03) 2022 2295 Customer Service Hotline: 1800 88 0812
tokiomarine.com

CF/OVERSEATRAVEL/062020



Attending Physician Statement

(To be completed by the Attending Physician)

1. Patient's Name: ______________________ Gender: ☐ Male ☐ Female

2. Date of Consultation: |_|_|_|_|_|_|_|_| (D D M M Y Y Y Y) ☐ Outpatient visit ☐ Admission

3. Diagnosis (Please indicate "✔" and specify):

   ☐ Sickness : ______________________

   ☐ Injury : ______________________

4. Does the sickness relate to one of the following types?

   ☐ Heart attack
   ☐ Hyperlipidemia
   ☐ Arthritis
   ☐ Alzheimer's disease
   ☐ Diabetes mellitus
   ☐ Rhinitis
   ☐ Anxiety
   ☐ Hypertension
   ☐ Hypercholesterolemia
   ☐ Gout
   ☐ Parkinson disease
   ☐ Cancerous disease
   ☐ Pneumonia
   ☐ Paralysis
   ☐ Any other prolonged illness *(Please specify)*
   ____
   ____

5. Has patient ever had the same or similar related condition or symptom before? ☐ Yes ☐ No

   If yes, when |_|_|_|_|_|_|_|_| (D D M M Y Y Y Y)

   Hospital: ______________________

6. Date of Patient's first visit/treatment for this condition: |_|_|_|_|_|_|_|_| (D D M M Y Y Y Y)

7. Please indicate "✔" if this sickness/consultation is:

   ☐ Pregnancy related
   ☐ Dental related
   ☐ Congenital condition
   ☐ Prior to inception of insurance cover
   ☐ Cosmetic
   ☐ Medical check-up/immunisation
   ☐ Chronic disease
   ☐ More than 180 days from the date of first treatment

   Sicknesses under the above category are excluded from policy, please charge patient accordingly.

Signature and stamp of Attending Physician

____

Name & Address:

____

____

____

____

Contact No. ______________________

Date of Report: |_|_|_|_|_|_|_|_| (D D M M Y Y Y Y)

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