eTiQa Takaful

TOTAL & PERMANENT DISABILITY CLAIM FORM

SECTION A

Every question must be fully answered. The Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Contract No : ______________________________

Agent's name & code :

Agent's Contact No. :

Instruction – Supporting documents required

- Total and Permanent Disability Claim form
- Total & Permanent Disability Statement of Medical Examiner
- Original certificate/policy contract
- Certified copy of Participant and/or Claimant's IC
- Letter of job termination from Participant's employer (if employed)
- Certified copy of clinic/ hospital consultation card
- Other supporting documents (if applicable)

Name of Participant ______________________________

New IC No ______________________ Old IC No. ______________________ Age ______

Correspondence Address ______________________________

____

Mobile Phone No. ______________________ E-mail address ______________________

Phone No. ______________________ Fax No. ______________________

What is the highest level of education do you have? Primary Secondary Tertiary Post graduate

1 Please list the jobs held in the past 3 years

Dates (From -To) dd/mm/yyyy)	Job Title & Employer's Address	Exact Duties of Work	Average monthly income (RM)

2 Name of the Employer prior to onset of disability ______________________

3 Address of Employer prior to onset of disability ______________________

______________________ Office Phone No. ______________________

4 Date of Employment ______________________ (dd/mm/yyyy)

5 Main duties prior to onset of disability ______________________

6 Work environment Factory Office Outdoors Type of industry ______________________

7 Are you in management or supervisory capacity? ______________________

8 Do you operate any machine or special equipments? Yes No

9 What is the qualification and/or skills needed for the job? ______________________

10 a. Any special skills required? ______________________

b. What is your normal working hours and days? ______________________

c. Are you required to work on shift, Sunday or on-call? ______________________

d. Any travelling (km/week) required by the job? ______________________

11 Condition/Disability due to Accident

a. When did the accident happen? Date: ____________ (dd/mm/yyyy) Time : ____________ (am/pm)

b. Where did the accident happen? ____________

c. What were you doing at the time of Accident? ____________

d. Describe in detail how the Accident happened ? ____________

____

12 Condition/Disability due to Illness

a. Describe fully the symptoms for which you consulted a medical practitioner. ____________

____

b. Date symptoms **first** commenced ____________ (dd/mm/yyyy)

c. Date you **first** consulted doctor for this condition ____________ (dd/mm/yyyy)

d. Name & address of doctor you **first** consulted for this condition ____________

____

e. What was the diagnosis? ____________

f. What treatment are you currently receiving? ____________

g. Have you previously sufferred from, or received treatment for a similar or related illness? Yes No

If yes, please give full details ____________

h. State the name and address of your regular doctor ____________

____

i. Please give details of any other doctors you have consulted in connection with this or other conditions.

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

13 When were you last able to work? ____________ (dd/mm/yyyy)

14 What aspects of your disability prevent you from following your occupation/any occupation?

____

____

15 State the date when you are expected to resume your work and daily activities ____________ (dd/mm/yyyy)

16 Do you intent to seek another employment? Yes No

If yes, the nature of work ____________

If no, why? ____________

17 Employment termination date ____________ (dd/mm/yyyy)

18 Are there other policies in force on your life taken with other companies ? Yes No

i. If yes, please give details:

Name of Company(s)	Commencement date (dd/mm/yyyy)	Contract no	Type of coverage	Sum assured

19 Please state your (the Claimant) bank account details in order for us to credit the payment directly into your bank account.

Bank : ______________ Account no: ______________

DECLARATION

I/We hereby declare that the foregoing answers and statements are complete and true to the best of my/our knowledge and belief, and that I/we have withheld no material facts from the Company.

____

Signature / Thumb print of Participant

Name ______________

Date ______________ (dd/mm/yyyy)

____

Signature / Thumb print of Claimant (if other than Participant)

Date ______________

Full name ______________

Contact No ______________

Designation & Official stamp is required for Company or Bank:

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Signature of Witness

Date ______________

Full Name ______________

NRIC No ______________

Contact No ______________

LETTER OF AUTHORISATION / CONSENT

TO OBTAIN FURTHER INFORMATION (LIVING TAKAFUL CLAIM)

To Whom It May Concern,

Contract No ______________________________

Dear Sir / Madam,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of employment, financial, health or medical history of myself ("the Particpant') and to provide such information to Etiqa Takaful Berhad or its authorised agents and/or employees.

I expressly waived all provisions of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on myself in a professional and/or client capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may rise, in supplying such information requested by the Company.

This authorisation / consent is irrevocable and a copy of it will have the same effect and validity as the original.

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Signature / Thumb print of Participant

Name ______________________________

NRIC ______________________________

Old IC ______________________________

Birth Cert No. (if minor) ______________________________

Tel No. ______________________________

Date ____________________ (dd/mm/yyyy)

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Signature of Contract holder (If Participant is a minor)

Name ______________________________

NRIC ______________________________

Old IC ______________________________

Tel No ______________________________

Date ____________________ (dd/mm/yyyy)

Etiqa Takaful Berhad (266243D)
Level 19, Tower C, Dataran Maybank, No 1, Jalan Maarof, 59000 Kuala Lumpur
T +603 2297 3888 F +603 2297 3800 E info@etiqa.com.my www.etiqa.com.my

Etiqa Oneline 1300 13 8888
Ahli Kumpulan Maybank