Gibraltar BSN

ACCIDENT CLAIM FORM
BORANG TUNTUTAN KEMALANGAN

PART I – CLAIMANT'S STATEMENT / *BAHAGIAN I - PERNYATAAN PIHAK PENUNTUT*

TYPES OF CLAIMS / *JENIS TUNTUTAN*

☐ **Weekly Indemnity /** *Pampasan Mingguan*
☐ **Medical Expenses /** *Perbelanjaan Perubatan*
☐ **Dismemberment /** *Faedah Pemisahan*
☐ **Snatch Theft /** *Manfaat Kecurian*

1. Policy Details & Life Assured Information / *Butiran Polisi & Orang yang Diinsuranskan*	
Policy No. / *No. Polisi*	
Name of Life Assured / *Nama Orang yang Diinsuranskan*	
NRIC No. of Life Assured / *No. KP Orang yang Diinsuranskan*	
Name of Claimant - If different from Life Assured / *Nama Penuntut- Jika berbeza daripada Orang yang Diinsuranskan*	
NRIC No. of Claimant - If different from Life Assured / *No. KP Penuntut- Jika berbeza daripada Orang yang Diinsuranskan*	
Correspondence Address / *Alamat Surat-Menyurat*	
Contact No. & Email Address / *No. Telefon & Alamat Emel*	
Life Assured is / *Orang yang Diinsuranskan menggunakan*	☐ **Right Handed /** *Tangan Kanan* ☐ **Left Handed /** *Tangan Kiri*
2. Employment Details / *Butiran Perniagaan / Majikan*	
Name of Employer / Business / *Nama Majikan / Perniagaan*	
Contact no. and Address of Employer / *Telefon dan Alamat Majikan / Perniagaan*	
Current occupation / *Pekerjaan sekarang*	
Exact occupational duties / *Butiran tugas yang tepat*	
Does it involve manual work / duties? / *Adakah ianya melibatkan kerja / tugas manual?*	☐ **Yes /** *Ya* ☐ **No /** *Tidak*
3. Accident details / *Butiran kemalangan*	
Date and time of accident / *Tarikh dan masa kemalangan*	**Date /** *Tarikh :* ☐☐ **DD /** *Hari* ☐☐ **MM /** *Bulan* ☐☐☐☐ **YYYY /** *Tahun* **Time /** *Masa :* ☐☐☐☐ **am/pm**
Place of accident / *Tempat kemalangan*	
How did the Accident Occur? / *Bagaimana kemalangan tersebut Berlaku?*	
Nature and extent of injuries, e.g. fracture, cut or bruises / *Tahap kecederaan yang dialami*	
Did you lose any body part? / *Adakah anda telah kehilangan anggota badan*	☐ **Yes /** *Ya* ☐ **No /** *Tidak*
4. Disability period details / *Butiran tempoh hilang upaya*	
Date first absent from work / *Tarikh hari pertama tidak hadir di tempat kerja*	**Date /** *Tarikh :* ☐☐ **DD /** *Hari* ☐☐ **MM /** *Bulan* ☐☐☐☐ **YYYY /** *Tahun*
Date return to work / Expected to work / *Tarikh mula bekerja semula / Dijangka bekerja*	**Date /** *Tarikh :* ☐☐ **DD /** *Hari* ☐☐ **MM /** *Bulan* ☐☐☐☐ **YYYY /** *Tahun*
State the date that you manage to fully perform all your duties / *Tarikh dan berupaya menjalankan tugas sepenuhnya*	**Date /** *Tarikh :* ☐☐ **DD /** *Hari* ☐☐ **MM /** *Bulan* ☐☐☐☐ **YYYY /** *Tahun*

5. Consultation / hospitalization details / *Butiran rundingan / kemasukan ke hospital*	
Name & Address of Doctor / Hospital / Clinic / *Nama & Alamat Doktor / Hospital / Klinik*	**Date of Consultation / Admission** *Tarikh Rawatan / Rundingan*
	☐☐ - ☐☐ - ☐☐☐☐ **DD /** *Hari* **MM /** *Bulan* **YYYY /** *Tahun*
	☐☐ - ☐☐ - ☐☐☐☐ **DD /** *Hari* **MM /** *Bulan* **YYYY /** *Tahun*

6. Other accident indemnity coverage / *Lain-lain perlindungan kemalangan*

Insurer / *Syarikat Insurans*	**Policy No. /** *No. Polisi*	**Amount of Benefit /** *Amaun Faedah*	**Effective Date /** *Tarikh Kuatkuasa*

7. Direct credit payment information / E-payment / *Maklumat pembayaran kredit terus / E-pembayaran*

Account holder's Name / *Nama Pemegang Akaun*		**Account holder's NRIC No. /** *No. KP Pemegang Akaun*	
Name of Bank / *Nama Bank*		**Bank Account No. /** *No. Akaun Bank*	

DECLARATION & AUTHORIZATION / *PENGISYTIHARAN & PEMBERIAN KUASA*

I, hereby declare that the information above is wholly and completely true. / *Saya, dengan ini mengisytiharkan bahawa maklumat di atas adalah semuanya benar dan lengkap.*

I / *Saya*, ____ **NRIC No. /** *No KP* : ______________________
hereby give consent to: / *dengan ini memberi kebenaran kepada*:

1. **The Company to hold, use or disclose my personal information to any hospital, clinic, physician, specialist, insurance or reinsurance companies, professional adviser or bodies, Life Insurance Association of Malaysia (LIAM), Ombudsman for Financial Services (OFS), Insurance Services of Malaysia (ISM), organization, institution or person(s) and authorized agents or representatives for the purpose of processing this applicationm. /** *Pihak Syarikat untuk memegang, menggunakan atau mendedahkan maklumat peribadi saya kepada mana-mana hospital, klinik, pegawai perubatan, dockor pakar, syarikat insurans atau insurans semula, penasihat atau badan professional, Persatuan Insurans Hayat Malaysia (LIAM), Ombudsman Perkhidmatan Kewangan (OFS), Insurance Services Malaysia Berhad (ISM), organisasi, institusi atau pihak dan ejen-ejen berdaftar atau wakil-wakil bagi tujuan pemprosesan permohonan ini.*

2. **For E-payment, I affirm that the information in this form is correct as at the date of form. I irrevocably consent to facilitate to the disclosure by the Company of my personal information to facilitate payment of all claim-refund that may be due to me. /** *Untuk E-pembayaran, saya mengesahkan bahawa maklumat dalam borang ini adalah betul seperti pada tarikh borang. Saya memberi keizinan untuk memudahkan pembayaran oleh pihak Syarikat maklumat peribadi saya untuk memudahkan pembayaran semua tuntutan bayaran balik yang mungkin kena dibayar kepada saya.*

____
Signature of Life Assured /
Tandatangan Orang yang Diinsuranskan

Date / *Tarikh:*

____
Signature of Claimant
(If different from Life Assured) /
Tandatangan Penuntut
(Jika berbeza daripada orang Diinsuranskan)

Date / *Tarikh:*

____
Signature of Witness /
Tandatangan Saksi

Name / *Nama:*

NRIC No. / *No. KP:*

Date / *Tarikh:*

Claim Documents Required (to submit together with this form) / *Sila hantarkan dokumen berikut kepada pihak Syarikat untuk pertimbangan*

- ☐ **Certificate of Medical Attendance /** *Kenyataan Pegawai Perubatan*
- ☐ **Original Tax Invoice & Receipts /** *Bil perubatan dan resit bayaran*
- ☐ **Medical Leave /** *Sijil cuti sakit*
- ☐ **Radiology Report e.g. X-ray, CT Scan etc /** *Laporan X-ray / pakar radiologi*
- ☐ **Perkeso / Socso Report /** *Borang tuntutan PERKESO - jika ada*
- ☐ **Full length of photo (for dismemberment only) /** *Untuk tuntutan dismembermen, gambar anggota badan Orang yang Diinsuranskan*
- ☐ **Police Reports /** *Laporan Polis*
- ☐ **Newspaper Cutting /** *Keratan Akhbar*
- ☐ **Copy of Life Assured's and Policyowner's NRIC/birth certificate or passport for foreigner /** *Salinan KP / Surat kelahiran / dari Orang yang Diinsuranskan / Pemilik Polisi atau Salinan pasport untuk warga asing*

Important Note / *Nota Penting:*
- **Company reserves the right to request additional documents subject to the condition and facts of the case /** *Syarikat berhak minta dokumen tambahan untuk kes khas.*
- **Being furnished or acknowledgment receipt of this claim by the Company does not amount to admission of liability /** *Pengemukaan atau pengesahan penerimaan borang ini oleh pihak Syarikat tidak dimaksudkan sebagai pengakuan liability.*
- **This claim is furnished or acknowledged on a without prejudice basis /** *Borang permohonan ini dikemukakan atau diterima tanpa prasangka.*

PART II – CERTIFICATE OF MEDICAL ATTENDANCE

1. Patient's Details					
Policy No.					
Name of Patient		Occupation			
NRIC No.		Age		Gender	☐ Male ☐ Female

2. Accident Details

a) Date and Time of Accident	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY	Time : ☐☐☐☐ am/pm
b) Date and Time of First Consultation	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY	Time : ☐☐☐☐ am/pm

c) How did the accident occur?

____

____

3. Injury Details

a) Were there any external and visible injuries as a result of the accident?	☐ Yes ☐ No
b) If yes, describe in detail the extent of injuries sustained as seen by you. Please provide measurement of injury (approximate)	
c) If no, describe any other evidence that is consistent with the accident claimed by patient	
d) In the event of any amputation, please state the site and extent of the amputation level e.g. proximal, middle, distal. *(Please attach diagrams if necessary)*	
e) In the event of any fracture, please state the location and type of fracture	
f) Please state details of POP / Backslab / Immobilization: -	
i. Date POP / Backslab / other immobilization was applied	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
ii. Date POP / Backslab / other immobilization was removed	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
iii. Date Physiotherapy started	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
iv. Date Patient started on full weight bearing	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
v. Please state the limitation of movement to any joint on the last date of consultation	

4. Treatment Details

a) Please provide type of treatment provided including follow-up treatments e.g. no. of stitches, STO, physiotherapy etc.

Date of Treatment	Healing Progress	Treatment / Type of Medication

b) Please describe the condition and function of injured part at last date of consultation	Last Date of Consultation ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY

c) Please explain the healing progress of injury. Please give details of complication of wound healing	☐ Straight Forward ☐ Complicated __________ __________
5. Hospitalization / Diagnostic Procedure Details	
a) Was the patient hospitalized?	☐ Yes ☐ No i) Hospital : __________ ii) Admission Date : DD MM YYYY iii) Discharge Date : DD MM YYYY
b) Was surgery performed?	☐ Yes ☐ No Name of surgery : __________
c) Were special Diagnostic Procedure/Treatment conducted or performed?	☐ Yes ☐ No Name of Procedure : __________
6. Other Illness, Disease or Infirmity Suffered	
a) Is or was the patient ever suffering from any illness, disease or infirmity? If yes, please state details and date /onset of diagnosis.	☐ Yes ☐ No __________ __________
b) Was there any evidence of intoxication or drug abuse? If yes, please give details.	☐ Yes ☐ No __________ __________
c) Were there any circumstances such as physical or medical history which may have contributed to the accident and/or prolonged the disability period? If yes, please give details.	☐ Yes ☐ No __________ __________

DECLARATION

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

Name : __________

Address : __________

____

Date : __________

Signature and Practice Stamp

Important Notice :

- All reports are to be submitted directly in a sealed envelope to the address stated below and stamped **"Private & Confidential".**

  Claims Department : Level 21, Mercu 2, KL Eco City, No. 3, Jalan Bangsar, 59200 Kuala Lumpur.

- Please attach certified true copy of relevant test results or imaging reports available.
- All expenses in procuring this medical report shall be borne by the claimant.