Gibraltar BSN

HOSPITALISATION & SURGICAL CLAIM FORM
BORANG TUNTUTAN HOSPITAL DAN PEMBEDAHAN

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

TYPES OF CLAIMS / *JENIS TUNTUTAN*

☐ **Hospitalisation / Day Surgery**
☐ **Hospitalisation Income / Surgical Benefits**
☐ **Hospitalisation Cash Benefit / Government Cash Allowance**
☐ **Outpatient / Pre & Post Hospitalisation Benefits**

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*	
Correspondence Address / *Alamat Surat-Menyurat*	
Contact No. and Email Address / *No. Telefon dan Alamat Emel*	
2. Claimant's Information / *Butiran Penuntut - jika berbeza daripada Orang yang Diinsuranskan*	
Name of Claimant / *Nama Penuntut*	
NRIC No. of Claimant / *No. KP Penuntut*	
Contact No. and Email Address / *No. Telefon dan Alamat Emel*	
3. Employment Details / *Butiran Perniagaan / Majikan*	
Current Occupation / *Pekerjaan Sekarang*	
Name of Employer / Business / *Nama Majikan / Perniagaan*	
Address and Contact no. of Employer / *Alamat dan no. telefon Majikan / Perniagaan*	
4. If hospitalisation due to accident (Accident & Injury Details) / *Jika kemasukan ke hospital kerana kemalangan (Butiran Kemalangan & Kecederaan)*	
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*	
5. If hospitalisation due to illness / disease (Illness / Disease Details) / *Jika kemasukan ke hospital kerana penyakit (Butiran Penyakit)*	
Sign of symptoms presented / *Jenis penyakit / simptom*	
How long had you been having these signs and symptoms? / *Berapa lamakah tanda-tanda dan simptom ini telah wujud?*	
Diagnosis / Nature of Illness / Disease / *Diagnosis / Jenis Penyakit*	

6. Details of hospitalisation / *Butiran kemasukan ke hospital*

Date of hospitalisation / *Tarikh kemasukan hospital*	**Admission:** / *Tarikh Masuk:* ☐☐ **DD** / *Hari* ☐☐ **MM** / *Bulan* ☐☐☐☐ **YYYY** / *Tahun*
	Discharge: / *Tarikh Keluar:* ☐☐ **DD** / *Hari* ☐☐ **MM** / *Bulan* ☐☐☐☐ **YYYY** / *Tahun*
Name and Address of the hospital / *Nama dan Alamat hospital berkenaan*	
Any surgery performed? / *Adakah pembedahan dijalankan?*	☐ **Yes** / *Ya* ☐ **No** / *Tidak*
If YES, please describe the body part involved / *Jika YA, sila terangkan bahagian badan yang terlibat*	**Details** / *Butiran* : _____

7. Details of previous consultation / *Butiran rawatan sebelum diagnosis*

Name & Address of Doctor / Hospital / *Nama & Alamat Doktor / Hospital*	**Date of Consultation / Admission** / *Tarikh Rawatan / Rundingan*	**Diagnosis/Nature of Illness/Disease** / *Diagnosis / Jenis Penyakit*
	☐☐ - ☐☐ - ☐☐☐☐ **DD**/*Hari* **MM**/*Bulan* **YYYY**/*Tahun*	
	☐☐ - ☐☐ - ☐☐☐☐ **DD**/*Hari* **MM**/*Bulan* **YYYY**/*Tahun*	

8. Other hospitalisation & surgical coverage with other insurance company / *Perlindungan hospital & pembedahan dengan syarikat-syarikat insurans lain*

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

9. Direct credit payment / E-payment information / *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 form.** / *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 (submitted 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
- ☐ **Copy of Itemised Bills** /
  Bill terperinci
- ☐ **Laboratory Test and Radiology Report** /
  Laporan makmal dan repot radiologi
- ☐ **Police Report if due to Accident** /
  Laporan Polis jika disebabkan kemalangan
- ☐ **Certification of Diagnosis / Discharge Note** /
  Diagnosis / Nota Discaj
- ☐ **Bank Statement / Bank note for direct credit verification** /
  Penyataan Bank untuk pembayaran terus
- ☐ **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

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

Medical Information	
1. Hospitalisation Details a) Date of Admission / Day Surgery b) Date of Discharge	a) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm b) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm
2. Was patient referred to you by another doctor? If "Yes", please indicate his/her name, address and provide a copy of referral letter.	☐ Yes ☐ No Doctor _____ Clinic / Hospital _____
3. If treatment due to accident, please provide details:- a) Date and time of Accident b) Nature of Accident	a) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm b) _____
4. Date you first saw the patient for this injury / illness	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
5. Please state symptoms which the patient complained of when first saw you for this injury / illness.	
6. How long had the patient been experiencing these symptoms?	☐ According to patient: _____ ☐ In your professional opinion: _____
7. Has the patient consulted another doctor for the same or similar symptoms as above in the past? If so, please give details.	☐ Yes ☐ No Doctor _____ Clinic / Hospital _____
8. Have any investigations, tests or procedures been performed? If Yes", please provide us the details or attach a certified true copy of the results.	☐ Yes ☐ No _____
9. Please state the diagnosis made.	
10. Please state the underlying cause and pathology.	
11. Date you inform the patient of diagnosis.	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
12. Nature of medical treatment given / surgery performed a) Name of Surgeon b) Date of Surgery / Operation c) MMA OPCS code/ PHFSR code	a) _____ b) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY c) _____
13. Is there a possibility of relapse?	☐ Yes ☐ No

14. Is the condition / treatment in any way related to the following:-

- ☐ **pregnancy, and complications thereof, childbirth, abortion, miscarriage, birth control, infertility**
- ☐ **alcoholism, drug addiction, self-inflicted injuries, suicide or attempted suicide**
- ☐ **birth defects, including hereditary conditions, and congenital sickness or abnormalities**
- ☐ **Elective, Cosmetic/ plastic surgery, routine health screening**
- ☐ **Psychotic / mental disorder which are not organics in nature / anxiety / sleep disorder**
- ☐ **Venereal disease, AIDS or any other illnesses in the presence of the Human Immuno-deficiency Virus (HIV)**
- ☐ **Hazardous sports, unlawful act**
- ☐ **Circumcision, sterilization of either sex, such as castration, vasectomy, and tubectomy**

Details: _____

_____

15. Has the patient been treated or hospitalised in this or any other hospital for this or any other serious disorders? If 'Yes', please give details.

Date	Diagnosis	Details of Treatment / Hospitalization	Doctor's / Hospital's Name & Address

16. Any other information which may help our claims assessment.

_____

_____

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.