Berjaya Sompo Insurance Berhad (62605-U)

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PERSONAL ACCIDENT CLAIM FORM (NON – FATAL)
BORANG TUNTUTAN KEMALANGAN DIRI (BUKAN MAUT)

Claim No. / *No. Tuntutan* _____ Policy No. / *No. Polisi.* _____
Agency / *Nama Ejen* _____

PLEASE ANSWER EACH QUESTION CLEARLY: TICKS OR DASHES ARE NOT SUFFICIENT / *SILA NYATAKAN JAWAPAN YANG LENGKAP BAGI SETIAP SOALAN: MEMBUAT TANDA (√) ATAU (-) ADALAH TIDAK MENCUKUPI.*

This form is issued without admission of liability and must be completed and returned within fourteen days after the occurrence of the accident. No claim can be admitted unless the medical report is furnished at the expense of the claimant. / *Borang ini tidak dianggap sebagai pengakuan liabiliti dan ia mesti dilengkapkan dan dikembalikan di dalam jangka masa empat belas hari selepas berlaku kemalangan. Tiada tuntutan yang sah melainkan penyerahan borang perubatan yang lengkap atas tanggungan perbelanjaan penuntut.*

1. Name of Insured / *Nama Pihak Yang Diinsuranskan* _____
   Address in full / *Alamat Penuh* _____
   Business / Occupation / *Pekerjaan* _____ Tel. No. / *No. Telefon* _____
   GST Registration No. / *No Pendaftaran GST* _____

2. Name of Claimant / *Nama Penuntut* _____
   New IC / Passport No. / *No. KP Baru / No. Pasport.* _____
   Address in full / *Alamat Penuh* _____
   Occupation / *Pekerjaan* _____ Tel. No. / *No. Telefon* _____ Date of Birth / *Tarikh Lahir* _____

3. Location / Place of accident / *Lokasi / Tempat kemalangan*	
4. Date and time of accident / *Tarikh dan masa kemalangan*	Date / *Tarikh* Time / *Masa*
5. Please describe clearly how the accident occurred and what you were doing at the time. / *Sila jelaskan bagaimana kemalangan berlaku dan aktiviti yang anda sedang buat semasa kemalangan.* (Use a supplementary sheet, if necessary / *Gunakan kertas berasingan jika ruang tidak mencukupi)*	
6. Please state the injuries sustained by you. / *Sila nyatakan kecederaan yang anda mengalami*	
7. Please provide names and addresses of any persons who witnessed the accident. / *Sila nyatakan nama dan alamat saksi kemalangan ini*	
8. (a) Please provide name and address of Medical Practitioner who attended you after the accident. / *Sila nyatakan nama dan alamat doktor yang merawat anda selepas kemalangan.* b) Is he your usual medical attendant? If not, please state the reason why he was consulted. / *Adakah doktor yang memberi rawatan tersebut doktor kebiasaan anda? Jika tidak, sila nyatakan sebab anda menerima rawatan dari beliau.*	

9. Please state whether in respect of the accident you are entitled to receive compensation from any other source. / *Sila nyatakan sama ada anda layak untuk menerima tuntutan dari sumber lain* If so, from what source and to what extent? / *Jika ada, dari pihak mana dan apakah jenis tuntutan?*	
10. Have you ever made a claim for compensation in respect of Accidental injury from any Insurance Company or elsewhere? If so, please state name of company, type of policy, amount and date of received. / *Adakah anda pernah membuat tuntutan pampasan mengenai kecederaan akibat kemalangan dari Syarikat Insurans lain. Jika ada, sila nyatakan nama syarikat, jenis polisi, jumlah dan tarikh menerima pampasan.*	
11. Mode of Payment required / *Cara pembayaran*	If claim is payable, arrange payment to / *Jika tuntutan diluluskan, pembayaran dibuat kepada* ☐ Policyholder / *Pemegang Polisi* ☐ Employee / Claimant / *Pekerja / Penuntut*

12. Please complete the below informations. / Sila lengkapkan maklumat di bawah.

Name of Account Holder(s) [Claimant(s)] / *Nama Pemegang Akaun [Penuntut]*		NRIC No(s). / *No KP Baru*	
E-mail Address / *Alamat Emel*	1.	E-mail Address / *Alamat Emel*	2.
Name of Bank / *Nama Bank*		Bank Account No. / *No. Akaun Bank*	
Business Registration No. / *No. Pendaftaran Perniagaan*		Contact No.(s) / *No. Telefon*	

The settlement sum paid or credited to my/our bank account will constitute a valid and final discharge of all your obligations as insurer due to me/us. / *Amaun bayaran ini atau dikreditkan ke dalam akaun bank saya/kami akan membentuk suatu pelepasan yang sah dan terakhir dari tanggungan anda sebagai pihak insurans.*

Further, I/We agree to discharge you, Berjaya Sompo Insurance Berhad from any liabilities loss and expenses including financial losses incurred by me/us in the event of me/us providing incomplete and incorrect information as stated above. / *Saya/Kami bersetuju untuk melepaskan anda, Berjaya Sompo Insurance Berhad dari sebarang liabiliti kerugian dan pembiayaan termasuk kerugian kewangan yang ditanggung oleh saya/kami ketika saya/kami memberi maklumat yang tidak lengkap atau tidak sah seperti dinyatakan di atas.*

Signature / *Tandatangan*

Name / *Nama* : _____ NRIC No. / *No KP Baru* : _____

DECLARATION AND AUTHORIZATION / *PENGISYTIHARAN DAN PEMBERIKUASA*

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I understand the delivery of this form is in no way an admission of Berjaya Sompo Insurance Berhad or its representative shall not be construed as final admission of Berjaya Sompo Insurance Berhad's liability and for this and any further claims arising, Berjaya Sompo Insurance Berhad reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my/Assured medical insurance under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract, or that is not covered by the same.

I hereby irrevocably authorize any organisation, 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 accident/injury, to disclose to Berjaya Sompo Insurance Berhad or its representative such information. I agree that Berjaya Sompo Insurance Berhad or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including Berjaya Sompo Insurance Berhad's parent company, subsidiaries or any other associated companies within Berjaya Sompo Insurance Berhad's Group, reinsurers, medical examiners, claims investigators and industry associates/federations etc) in relation to this claim. This authorization shall bind my/the Assured's/Insured's successors and assigns and remain valid notwithstanding my/Assured's/Insured's incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original. I agree that in the event I make, or have in the past made, any false or untrue statement and/or suppressed and/or concealed any material facts in respect of my/the Insured's condition, Berjaya Sompo Insurance Berhad shall absolutely forfeit my/the Insured's/Assured's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti Berjaya Sompo Insurance Berhad ini ke atas tuntutan saya/Asured dan saya bersetuju bahawa bayaran kepada hospital oleh Berjaya Sompo Insurance Berhad atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti Berjaya Sompo Insurance Berhad dan Berjaya Sompo Insurance Berhad berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had insurans saya di bawah Polisi yang tersebut diatas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh insurans berkenaan.

Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/Asured/Insured, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada Berjaya Sompo Insurance Berhad atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan Berjaya Sompo Insurance Berhad atau wakilnya untuk mengguna dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak Berjaya Sompo Insurance Berhad atau Berjaya Sompo Insurance Berhad berkait dalam Berjaya Sompo Insurance Berhad, reinsurer, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/Asured/Insured dan kekal sah meskipun setelah kematian saya/Asured/Insured setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, Berjaya Sompo Insurance Berhad berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Date / *Tarikh*

Signature of Claimant (if the Claimant is company, authorised signature(s) and company stamp)
Tandatangan Penuntut (Jika Penuntut adalah syarikat, tandatangan dan cop syarikat yang sah)

TO BE COMPLETED BY ATTENDING DOCTOR

1. Name of Claimant _____
   New IC / Passport No. _____
   Occupation _____ Date of Birth _____

2. (a) Date of Accident	(a) _____
(b) The cause of accident, so far as known to you	(b) _____
(c) When and where first seen after accident?	(c) _____
(d) Are you still attending to the claimant?	(d) _____
(e) Give date of last visit to or by the claimant?	(e) _____
3. Are you the claimant's regular medical attendant? If Yes, since when and for what treatmant, please give details.	☐ Yes ☐ No _____
4. Please state exact nature and extent of the injuries sustained. If a limb or an eye state whether it is the Left or Right.	_____
5. (a) Are his injuries (i) solely due to the accident, or (ii) traceable to disease, infirmity or any other cause? If Yes, please give details.	(a) (i) ☐ Yes ☐ No (ii) ☐ Yes ☐ No _____
(b) Has he ever suffered from Gout, Rheumatism, Diabetes, Fits or Heart problems?	(b) _____
(c) Is there anything in his medical history which may have contributed, directly or indirectly, to the accident or which may be likely to retard his recovery?	(c) _____
(d) Have you any reason to suppose that he was under the influence of intoxicants/drugs at the time of accident?	(d) _____
6. Do you consider there will be any permanent disability? If so, please elaborate as detailed as possible on the nature and extent of disability.	_____
7. In my opinion. The claimant has sustained the following degree of disablement as a result of accident.	
(a) Temporary Total Disablement i.e claimant totally unable to attend to duty or any business or occupation.	(a) For _____ Days From _____ To _____
(b) Temporary Partial Disablement i.e claimant can attend to part of work /duty /business or occupation.	(b) For _____ Days From _____ To _____
8. If the claimant has been totally disabled (temporary) for more than two weeks from attending to his usual duty, please describe in detail the reason why the patient cannot work or attend to his business affair keeping in mind the occupation of the claimant.	_____

I certify that i have satisfied myself by personal examination that the claimant has sustained an accident causing injuries as above described, and to the best of my belief the foregoing statements are correct.

Signature : _____ **Name of Hospital / Clinic** : _____

Name : _____ **Address** : _____

Qualification : _____

Date : _____