BERJAYA SOMPO INSURANCE

Claim Form

HOSPITAL AND SURGICAL INSURANCE

PART I: TO BE COMPLETED BY CLAIMANT			
SECTION 1 – POLICYHOLDER / EMPLOYEE DETAILS (for Group Insurance or patient is dependent)			
Policyholder Name		Date of Employment	
Employee Name			
Policy No.		Tax Identification No. (TIN)	
Mobile No.		E-mail Address	
SECTION 2 – PATIENT DETAILS			
Patient Name			
NRIC / Passport No.		Date of Birth	
Mobile No.		E-mail Address	
SECTION 3 – E-PAYMENT FOR PROMPT SETTLEMENT			
Name of Account Holder		NRIC / Passport No.	
Bank Account No.		Business Registration No.	
Name of Bank		E-mail Address	
Note: 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.			
SECTION 4 – STATEMENT BY CLAIMANT (By Parent if claimant is a minor)			
For Accident, please state the location			

Date and Time of Accident	Date		Time	
Please describe clearly how the accident occurred and what you were doing at the time (Use a supplementary sheet, if necessary)				
For Sickness, please specify the diagnosis				
Do you have other parties covering this loss? If yes, please provide	Received from			
	Amount received			

DECLARATION AND AUTHORISATION

I hereby declare that to the best of my knowledge and belief, the above details/information as provided by me are true and complete and I understand that the Company reserves all rights for final evaluation as appropriate on all or any part of the claims made. If I made or shall make any false/fraudulent statements, or withhold any material facts whatsoever in respect of this claim, I shall forfeit all rights to recover from the Company.

I authorise any hospital's doctor and/or other person who has attended or examined me, to furnish to the Company, and/or its authorised representatives, all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

I hereby authorise any Insurer/s to give full particulars about my claim history to Berjaya Sompo Insurance Berhad.

I hereby authorise any relevant merchant (as shown as supporting document/s on this insurance claim) to give full particulars about my purchased history to Berjaya Sompo Insurance Berhad.

In relation to the personal information collected in this claim form, I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority or obtained the consent to provide that information to the Company and/or its service provider, and have informed the said individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the Company and/or its service provider, and the individual agrees and consents, that the Company and/or its service provider may collect, use and process my/his/her personal information for the purpose as it was provided and as indicated in the Company's Privacy Notice at www.berjayasompo.com.my

Signature : _____ Name : _____ Date : _____

*If Claimant is company, please affix company stamp

PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN/SURGEON			
1.	Name of Patient:	2.	Name of Hospital:
3.	Admission Date and Time:	4.	Discharge Date and Time:
5.	Symptoms / Conditions requiring admission:		
6.	Vital signs: Temperature: _____ Pulse: _____ BP: _____		
7.	Provisional Diagnosis:	8.	Date you were first consulted:
9.	Have you seen this patient before for other problem? ☐ Yes ☐ No (if Yes, please provide date and type of problem)		
10.	Was this patient referred to you? ☐ Yes ☐ No (if Yes, please provide doctor's name and address or referral letter)		
11.	Has patient ever had the same or similar related conditions or symptoms before? ☐ Yes ☐ No (if Yes, please state when)		
12.	Name and address of doctors previously consulted by patient for the condition.		
13.	How long in your professional opinion has the condition existed? _____ days _____months _____ years		
14.	Final Diagnosis / ICD Coding:		
15.	Cause and pathology (if applicable) for the above diagnosis:		
16.	Is this admission primarily for investigation ☐ Yes ☐ No		
17.	Medical treatment, Investigations and Surgical procedure performed, if any (please provide copy of results)		
18.	Any other medical / surgical conditions present? ☐ Yes ☐ No if Yes, please provide details a. _____ since _____ dd/mm/yyyy b. _____ since _____ dd/mm/yyyy c. _____ since _____ dd/mm/yyyy		
19.	Insured's past medical history (if any) a. _____ _____ dd/mm/yyyy b. _____ _____ dd/mm/yyyy c. _____ _____ dd/mm/yyyy		
20.	Is the illness or condition related to: (please tick (√) if Yes a. Congenital / Hereditary ☐ b. Influence of Drugs / Alcohol ☐ c. Anxiety / Mental / Nervous / Emotional disorder ☐ d. AIDS / STD / VD / HIV ☐ e. Self-inflicted injuries / Violation of laws / Strike / Riots ☐ f. Cosmetic / Plastic surgery ☐ g. Dental care / refractive errors correction ☐ h. Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage or any complications arising therefrom ☐		
21.	Can this sickness or injury be treated as: a. Outpatient basis? ☐ Yes ☐ No b. Day surgery basis? ☐ Yes ☐ No (if No, please provide details)		
22.	Was the patient pregnant at the time of hospitalization? (For female patient only) ☐ Yes _____ months ☐ No		
23.	If hospitalization was due to accident, please indicate: Date: _____ dd/mm/yyyy Time: _____ am/pm Nature of accident: Extent of injury:		
24.	I hereby certify that I have personally examined and treated Patient for his / her injuries / illness described above and that the facts as stated above represent my medical opinion of his / her condition. _____ _____ _____ Date Name & Signature of Attending Doctor Doctor / Hospital Stamp		