



KOPERASI CUEPACS ETIQA MUTIARA PLUS

Wisma Koperasi Cuepacs, No.24-4, Jln 15/48A,
Sentul Raya Boulevard, 51000 Kuala Lumpur.
Tel : 03-40440817/03-40429476 Faks : 03-40429475



Pastikan document **disahkan benar lengkap mengikut arahan** sebelum dihantar **agar tidak berlaku penolakan.**

PERKARA: PERMANENT PARTIAL DISMEMBERMENT (PPD)

NOTA : Nama Penuh Peserta merujuk kepada **PESAKIT**

- Sijil penyertaan **TKM0578/TTMW31**. Jika tiada tetapi menjadi ahli **melebihi 60 hari** peserta layak membuat tuntutan. Sila lampirkan surat pengakuan jika tiada sijil.

Dokumen yang perlu dilampirkan:

TYPES OF CLAIMS	DOCUMENTS REQUIRED
Total & Permanent Disability	<ol style="list-style-type: none">1) Permanent Partial Dismemberment Claim Form2) Permanent Partial Dismemberment Statement of Medical Examiner3) Certified copy of Insured / Life Assured / Person Covered Participant's Ic4) Certified copy of police report (if any)5) Close-up photograph as proof of loss / Full photo of claimant6) Consent Letter for medical report extraction7) Certified copy of X-ray, MRI, Ct scan or other radiology reports8) Other supporting document (if applicable)

Jika dokumen sokongan diberikan dalam salinan, dokumen tersebut mestilah disahkan oleh mereka yang dibenarkan oleh Syarikat, Pesuruhjaya Sumpah, 'Notary Public', Peguam, Jaksa Pendamai, Ahli Parlimen, Ketua Balai Polis, Penghulu atau Pegawai Daerah.

ETIQA GROUP CLAIMS SUBMISSION CHECKLIST

GROUP MAJOR & HOSPITAL BENEFITS CLAIMS

Note: We reserve the rights to request further documents if required

Please tick (✓) where applicable;

COMPULSORY FOR ALL CLAIM TYPE SUBMISSION:	
	Etiqa Group Claim Form : Group Major & Hospital Benefits Claims
	Certified copy of Claimant's / Payee's NRIC
	Bank Account Details of Payee and Company Registration Number (If payee is Contract/Policy holder)

DEATH / FUNERAL EXPANSES / KHAIRAT CLAIM	
	Death Statement of Medical Examiner (for policy duration < 5 years)
	Certified copy of Death Certificate
	Proof of relationship between claimant and Participant/Life Assured: Certified copy of ANY one below: <ul style="list-style-type: none"> - Marriage/ Nikah Certificate if claimant is spouse - Birth Certificate (s) of Child if claimant is child/Children - Birth Certificate (s) of Deceased if claimant is parent (s) - If above is not available, please submit statutory declaration
	Certified copy Sijil Faraid /Court Orders / Letter of Administration (if applicable)
	If death occurred in Overseas: <ul style="list-style-type: none"> - Confirmation letter from National Registration Department (for death outside of Malaysia) - Death Certificate issued by the country where death occurred (if any) - Certification of death from the hospital where death occurred (if any) - Certification of death from the Malaysian Embassy in the foreign country where death occurred (if any)

ACCIDENTAL DEATH CLAIM	
	Death Statement of Medical Examiner
	Certified copy of Death Certificate
	Certified copy of : Police Report , Post Mortem report (if any), Newspaper/Online News cutting (Where applicable)
	Proof of relationship between claimant and Participant/Life Assured : Certified copy of ANY one below: <ul style="list-style-type: none"> - Marriage/ Nikah Certificate if claimant is spouse - Birth Certificate (s) of Child if claimant is child/Children - Birth Certificate (s) of Deceased if claimant is parent (s) - If above is not available, please submit statutory declaration
	Certified copy : Sijil Faraid /Court Orders / Letter of Administration (Where applicable)

TOTAL & PERMANENT DISABILITY CLAIM	
	Total & Permanent Disability Claim - Statement Of Medical Examiner (Group) Section B (Completion of Section B must be done six months after the diagnosis/disability date)
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports
	Certified copy of Medically Boarded Out letter from employer (if employed)
	Certified copy Other supporting documents (if applicable) etc. SOSCO Pencen Illat medical reports/letters

PERMANENT PARTIAL DISMEMBERMENT/ DISABILITY CLAIM	
	Permanent Partial Dismemberment - Statement Of Medical Examiner Section B (Completion of Section B must be done six months after the diagnosis/disability date)
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

ACCIDENT MEDICAL REIMBURSEMENT (AMR) CLAIM	
	Original official receipts and bills
	Discharge note /summary with diagnosis or Medical Report
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports
	Certified copy other supporting documents (if applicable) etc. Police report

HOSPITAL BENEFIT / DAILY HOSPITAL ALLOWANCE CLAIM	
	Original official receipts and bills
	Discharge note /summary with diagnosis or Medical Report
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

TERMINAL ILLNESS BENEFIT CLAIM	
	Critical Illness (Others) – Statement Of Medical Examiner (Group Claim)
	Letter from attending physician stating the current patient’s condition, treatment and prognosis.
	Certified copy of MRI/CT Scan/ Xray or other diagnostic reports

CRITICAL ILLNESS BENEFIT CLAIM

- Medical Examiner Form to be completed according to the type of critical illness:
1. Critical Illness (Cancer) – Statement Of Medical Examiner (Group Claim)
 2. Critical Illness (Stroke) – Statement Of Medical Examiner (Group Claim)
 3. Critical Illness (Renal Failure) – Statement Of Medical Examiner (Group Claim)
 4. Critical Illness (Heart) – Statement Of Medical Examiner (Group Claim)
 5. Critical Illness (Others) – Statement Of Medical Examiner (Group Claim)

List Of Covered Events And The Required Medical Evidence

Stroke - CT Scan / MRI Report of Brain	Parkinson's Disease - All relevant investigation results in support of the diagnosis
Heart Attack / Cardiomyopathy - Cardiac Enzymes Assay results (CK-MB, Troponin T / Troponin I) - ECG tracing - Echocardiogram / Coronary Angiogram report	Blindness - Permanent and Irreversible - Visual Acuity Report on both eyes to be done by an ophthalmologist * CMC to be completed by an Ophthalmologist.
Angioplasty and other invasive treatments for coronary artery disease - Coronary Angiogram Report Coronary Artery By-Pass Surgery - Coronary Artery By-Pass Surgery Report Heart Valve Replacement / Surgery - Heart Valve Surgery Report	Chronic Lung Disease - Pulmonary Function Test results - Arterial Blood Gas test results - FEV 1 Test results - Relevant investigation results
Cancer - Histopathology Report (HPE report) - CT Scan / MRI Reports, if available - Bone Marrow Aspiration / Trephine Biopsy Report (Leukemia only) - Blood and laboratory test report	Motor Neuron Disease - CT Scan/ MRI report of the Brain and Spine - Electromyography (EMG) test results - All relevant investigation results in support of the diagnosis - Medical Report to be completed by Neurologist
Renal / Kidney Failure / Medullary Cystic Disease - Kidney Dialysis Report / Dialysis Receipts - Kidney/Renal Biopsy Report (if any) - Blood test results	Multiple Sclerosis - CT Scan & MRI Report of Brain & Spine - Nerve conduction study / Evoked potential test * Medical Report to be completed by Neurologist
Systemic Lupus Erythematosus (SLE) With Lupus Nephritis - Lupus Erythematosus (LE) cell blood test results - Anti-DNA Antibodies & Renal biopsy report - Urine FEME results over past 6 months - Renal function tests with eGFR results over past 6 months	Coma – resulting in permanent neurological deficit with persisting clinical symptoms - ICU report and supporting documents for being in come > 96 hours - X-ray/CT Scan/ MRI Reports - Medical Report to be completed by Neurologist
Fulminant Viral Hepatitis / End-Stage Liver Failure/ Chronic Liver Disease - CT Scan Report of Liver - Liver Function Test results - Abdominal ultrasound - Hepatitis viral serology test - Any other laboratory or pathology reports	Muscular Dystrophy - Lumbar puncture report - Electromyography (EMG) test results - Muscles biopsy - All relevant investigation results in support of the diagnosis - Medical Report to be completed by Neurologist
Brain Surgery - Brain Surgery Report	Terminal Disease - All relevant investigation results in support of the diagnosis - Medical Report stating patient not receiving active treatment other than pain relief.
Benign Brain Tumor - CT Scan / MRI Report of Brain - Histopathology Report, if available	Chronic Aplastic Anemia - resulting in permanent Bone Marrow Failure - All relevant blood and bone marrow investigation results in support of the diagnosis - Bone Marrow transplantation report
Major Head Trauma - CT Scan / MRI Report of Brain - Surgery report - Police report, if any	Alzheimer's disease/Severe Dementia / Parkinson's disease - All relevant investigation in support of the diagnosis - Medical Report to be completed by Neurologist - Physio / Rehabilitation Reports (if Any)
Bacterial Meningitis / Encephalitis - CT Scan / MRI Report of Brain /Spine - CMC to be completed by Consultant Neurologist - Lumbar puncture test report	Deafness – Permanent and Irreversible - Audiogram Report (Latest Report) - Pure Tone Audiometry reports (Latest Report)
Major Burns / Third Degree Burns - Total Body Surface Area Burn Assessment Report	Loss of Speech - Laryngoscopy report
Paralysis / Paraplegia / Paralysis of limbs - X-ray/CT Scan/ MRI Reports, if available - Medical Report to be completed by Neurologist	Major Organ / Bone Marrow Transplant -Transplantation report of heart or lung /liver /kidney /pancreas / bone marrow

Note: Kindly contact our sales/agents or customer service for illness/requirements which is not listed above.

Section C: Details of Claims

Claim Type : Death/ Accidental Death /Funeral Expenses/ Khairat Claim			
Date of Death (dd/mm/yyyy)		Last Working Date (If employed)	
Any Post Mortem Done?	<input type="checkbox"/> Yes (Please provide copy of the report)	<input type="checkbox"/> No	

Claim Type : Hospitalisation /Critical Illness/ Terminal illness /AIR Weekly Indemnity Claim			
Date of Admission (dd/mm/yyyy)		Date of Discharge (dd/mm/yyyy)	
Admitted Hospital			
Diagnosis			
First Date of Signs & Symptom for the Diagnosis (dd/mm/yyyy)		Medical Certificate (MC) Dates (dd/mm/yyyy)	
Date of Accident (dd/mm/yyyy)		Place of accident	

Claim Type : Total / Partial Permanent Disability Claim			
Date of Admission (dd/mm/yyyy)		Date of Discharge (dd/mm/yyyy)	
Diagnosis			
First Date of Signs & Symptom for the Diagnosis (dd/mm/yyyy)		Medical Certificate (MC) Dates (dd/mm/yyyy)	
Date of MC/ Prolonged Illness Leave	Start Date (dd/mm/yyyy):	End Date (dd/mm/yyyy):	
Current Salary Status	<input type="checkbox"/> Full Salary	<input type="checkbox"/> Half Salary	<input type="checkbox"/> No Salary
Last Drawn Monthly Basic Salary	Paid Date (dd/mm/yyyy)		Salary Amount RM
Last Working Date (dd/mm/yyyy)		Date of Resignation /Medically Boarded out / Early Retirement (if any)	

DECLARATION

I do solemnly and sincerely declare that I am the nominee/administrator/beneficiary for the Takaful benefit of the deceased and further declare as follows:-

- That the foregoing answers and statements on the Deceased are complete and true to the best of my knowledge and belief, and that I have withheld no material facts from the Company.
- That any difference, if any, in respect of the details contained in the enclosed supporting document and the information presented to Etiqa Takaful Berhad(Etiqa) in this form refers to the same person. I understand and agree that Etiqa has the sole discretion to reject this application if the information given is false or insufficient.
- That the original certificate whether or not enclosed therein (if any), due to loss or mutilated, belongs to the deceased.
- And I hereby authorize any medical practitioner, surgeon person, hospital, clinic and any other institution or organization to furnish Etiqa Takaful Berhad or its representative any information that may be required concerning my health conditions, for settlement of this claim. I agree that Etiqa Takaful Berhad or its representative may use or disclose any of the information collected or held to third parties such as reinsurers, medical examiner or medical consultant, claims investigator and etc. within or outside Malaysia for the purpose of processing the claim. I agree that a photocopy of this authorization shall be considered as effective and valid as original.
- I, agree, consent and allow Etiqa Family Takaful Berhad (hereinafter called "Etiqa Takaful") to process my personal data (including sensitive personal data) ("Personal Data") with the intention of processing this Claim Form, in compliance with the provisions of the Personal Data Protection Act 2010.
- I, understand and agree that any Personal Data collected or held by Etiqa Takaful contained in this Claim Form may be held, used, processed and disclosed by Etiqa Takaful to individuals and/or organizations related to and associated with Etiqa Takaful or any selected third party (within or outside Malaysia, including medical institutions, solicitors, industry associations, regulators, statutory bodies and government authorities) for the purpose of processing this Claim Form and providing subsequent service related to it and to communicate with me for such purposes.
- I agree that a copy of documents submitted shall be as valid as the original. I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution.

Date

Date:

PERMANENT PARTIAL DISMEMBERMENT - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Participant for the injuries / illness sustained.
2. Expenses incurred to obtain this report will be borne by the Participant.

Contract No:

1. Name of Patient:					
2. NRIC No. : BC / Old IC No. : Age:					
3. Occupation as indicated to you :					
4. Date of <u>first</u> consultation with you: (dd/mm/yyyy) Time :(am/pm)					
5. Diagnosis:					
6. Date of diagnosis:(dd/mm/yyyy)					
7. What was the underlying cause and pathology of the above diagnosis?					
8. If the cause was due to accident, please state					
i. Date of Accident : (dd/mm/yyyy) Time :(am/pm)					
ii. Describe in detail the nature of accident as related to you by the patient:					
iii. Was the patient under the influence of intoxicating liquor, drug or narcotic at the time of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
9. Treatment given including follow up consultation :-					
Date of consultation (dd/mm/yyyy)	Treatment given	Healing Progress			
10. Details of Hospitalization					
Name of Hospital	Date of Admission (dd/mm/yyyy)	Date of Discharge (dd/mm/yyyy)	Type of Surgery Performed	Date of Surgery (dd/mm/yyyy)	Other Diagnosis Procedures or Treatment
11. Was the patient referred to you by any doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No					
i. If yes, please indicate the name of doctor and address of the clinic / hospital.					
ii. Please attach a copy of the referral letter, if any.					

12. Date of full weight bearing(dd/mm/yyyy)

13. Was the healing complicated, eg: infection, malunion etc? Yes No

i. If yes, please give details of complications.....

14. Did the patient suffer amputation of limbs? Yes No

i. If yes, please stated level of amputation seen (proximal, middle, distal)
.....

15. Last date of consultation :(dd/mm/yyyy)

16. Condition of healing / recovery of the injury / illness as at last consultation date
.....

17. Did the patient suffer any loss of use of limbs and /or fingers? Yes No

Please state the power of patient's upper and lower limbs as at last consultation date

i. Right Upper Limb : Right Lower Limb :

ii. Left Upper Limb : Left Lower Limb :

18. Did the patient suffer any loss of eyes? Yes No

Please give details on patient's Visual Acuity as at last consultation; (i) Right eye : (ii) Left eye :

19. Did the patient suffer any loss of hearing? Yes No

Please give details on patient's hearing as at last consultation, (i) Right ear :db (ii) Left ear :db

20. Does the patient suffer any limitation of movement on any joint as at last consultation date? Yes No

i. If yes, please state the limitation and range of movement
.....

21. Please state the percentage(%) of whole person impairment according to AMA guidelines (completed by Specialist)
.....

22. If the patient was diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him / her starting from the first recording done :

<u>Date (dd/mm/yyyy)</u>	<u>Readings of Blood Pressure</u>	<u>Date (dd/mm/yyyy)</u>	<u>Results for Blood Glucose (Fasting)</u>
i.	i.
ii.	ii.

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : _____

Name of Doctor : _____ Qualification : _____

Telephone No. : _____ Fax No. : _____

Date : _____(dd/mm/yyyy)

Official Stamp of Doctor : _____ Name and Address of Clinic / Hospital Official Stamp