Personal Accident Claim Form

Important Notice:

- *The participant/policy holder/claimant must give complete and accurate information.*
- *For your easy accessibility, this claim form is made available at our website www.etiqa.com.my*

Claim Supporting Document Checklist

Document Name	***Claims Type***		
	Funeral Expenses Claims	***Permanent Disability Claim***	***Death Claim***
1. Police report	X	X	X
2. Copy of MyKad / Marriage certificate / Birth certificate	X	X	X
3. Medical specialist report		X	
4. Full photograph of injured person & affected limbs (for amputation only)		X	
5. SOSCO notification	X	X	X
6. Death certificate	X		X
7. Burial permit	X		X
8. Post-mortem report (full)	X		X
9. Letter of administrator	X		X
10. Others (if any)	X	X	X

Information on policyholder

Policy no.:				
Name of policyholder:				
MyKad / Army / Police / Passport no./ Business registration no.:			Occupation:	
Contact details	Phone no.	Mobile:	House:	Office:
	Email:			
Address Postcode	Town	State		Country
Bank name:			Account no.:	

Details of injured person

Name of patient:				
MyKad / Army / Police / Passport no.:				
Contact details	Phone no.	Mobile:	House:	Office:
	Email:			
Address Postcode	Town	State		Country
Relationship of patient to policyholder:				

Details of accident

Date of accident (dd/mm/yyyy):		Time (am/pm):	
Location of accident:			
Describe in detailed how the accident occurred:			
Describe the injuries sustained:			
Were you in a public transport at the time of accident?	☐ Yes	☐ No	
	If yes, please specify the type of public transport:		

Doctor who attended the injured person:	Name		
	Address of hospital/ clinic Postcode Town State Country		
	Mobile	House	Office
Family doctor (if any):	Name		
	Address of hospital/ clinic Postcode Town State Country		
	Mobile	House	Office

Declarations

I/We declare that the above statements and particulars are correct and complete in every aspect and I/We have not concealed, misrepresented or misstated any material fact in relation to this claim.

I/We hereby authorize any hospital or clinic doctor or any other person who has attended or examined me to disclose to Etiqa General Insurance Berhad full particulars in respect to any illness and injury, medical history, consultation, prescription or treatment. A duplicate of this authorization shall be considered as effective and valid as the original.

Signature of patient
Date

Signature of policyholder
Date

Note: For death claim, next-of-kin is to sign.