



اينسورنس ناسيونل

National Insurance Company Berhad

(Incorporated in Negara Brunei Darussalam)

Head Office : 3rd Floor, Scouts Headquarters Building, Jalan Gadong BE1118, Brunei Darussalam
P. O. Box 1251, Bandar Seri Begawan BS8672, Brunei Darussalam.

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B.S.B : 6th Floor, Jalan Sultan Complex, Bandar Seri Begawan BS8811, Brunei Darussalam
Tel: 2233999 Fax: 2238999 Email:bsb@national.com.bn

Kuala Belait : F119A, 1st Floor, Kompleks Harapan, Jalan Setia DiRaja, Kuala Belait KA3131, Brunei Darussalam.
P. O. Box 1336, Kuala Belait KA1131, Brunei Darussalam
Tel: 3331527, 3342192 Fax: 3342191 Email: kb@national.com.bn

MEDICAL CLAIM FORM

IMPORTANT NOTES :

- 1) The National Insurance Company Berhad hereby referred to as "The Company"
- 2) The Company does not admit liability by the mere issue of this or any other form
- 3) Forward all original medical bills and hospital receipts
- 4) To be completed by the Life Insured
- 5) Please delete where appropriate

DOCUMENTS REQUIRED TO BE SUBMITTED

- | | |
|--------------------------------|--------------------------|
| 1) Medical Expenses Claim Form | <input type="checkbox"/> |
| 2) Original Medical bills | <input type="checkbox"/> |
| 3) Medical Report | <input type="checkbox"/> |

1) POLICY DETAIL

Policy number :

Policy effective date : From To

Name of Policyholder :

2) DETAILS OF LIFE INSURED

Name of Insured :		MEDICAL CLAIM FORM	
NRIC/Passport No:		Marital status :	
Date of employment :	(dd/mm/yy)	Date join the scheme :	(dd/mm/yy)
Occupation & description of duties :		Relationship to Policyholder	
Residential address :			
Contact No :		Email address :	
(H)	(O)	(HP)	

3) NATURE OF CLAIM AND RELATED DETAILS

a) Describe fully the symptoms for which the Life Insured consulted a doctor.
b) How long did the Life Insured have the symptoms before he/she consulted a doctor ?
c) Date when the Life Insured first consulted a doctor. (dd/mm/yy)
d) If consultation was for illness, describe fully the extent and nature of the Life Insured's illness.

e) Has the Life Insured previously suffered from or received treatment for a similar related illness?

f) If consultation was due to an accident, please provide the following :

i) Date of accident : (dd/mm/yy)	ii) Time of accident :	iii) Place of accident :
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iv) Detail description of the accident :

v) Name(s) and address(es) of witness(es) :

4) RECORD OF MEDICAL CONSULTATIONS

a) Was the Life Insured treated on an out-patient or in-patient basis ? Out-patient/in-patient

b) Provide the name(s) and address(es) of the Life Insured's regular doctor(s) :

Name(s)	Address(es)	Reason(s) for Consultation

(Skip questions 4 (c) to 4 (e) if treated on an out-patient basis).

c) How was the Life Insured admitted to the hospital? (please tick)

Referral by a General Practitioner/Specialist/Other Hospital.

Please provide details : _____

A & E department

d) Details of hospitalisation :

Name of Hospital	Period of Hospitalisation		Name of Attending Doctor
	From	To	

e) Provide the details of any doctors who have been consulted in connection with the Life Insured's illness/condition at any time before the hospitalisation:

Name(s)	Name(s) of Clinic(s)/Hospital and Address	Date of First consultation

5) OTHER MEDICAL INSURANCES

Name of Insurer	Date of Issue	Type of Plan	Claim Amount	Claim Notified (Yes/No)

Declaration

I declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted. I agree to The Company seeking information in connection with this claim from any source and I authorise the giving of such information. A photocopy of this authorisation is as valid as the original.

Declared on _____ of _____ 200_____

 Authorised Signature and Company Stamp

 Signature of Claimant

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Claim No :		
Annual benefit :		Claim Amount :
Aggregate claims paid in current policy year :		
Deductible :		Amount payable
Signature :		Date :
		Reinsurer's share

**Medical Expenses Claim
Doctor's Statement**

DETAILS OF LIFE INSURED

Name of Life Insured :

NRIC/Passport No :

1. Are you the Life Insured's usual medical doctor ?
If "yes", since what date ?

Yes/No
(dd/mm/yy)

2. Date of first consultation for the current medical condition :

3. Was the Life Insured treated on an out-patient or in-patient basis ?

Out-patient/in-patient

4. Please state symptoms presented and date symptoms first appeared :

Symptoms presented at first consultation

Date symptoms first started (dd/mm/yy)

5. Please provide details (including date, type and result) of investigation done.

6. Diagnosis :

7. Date diagnosis was made known to the Life Insured :

(dd/mm/yy)

8. Please describe the treatment / medication given and the response.

9. Is the Life Insured suffering or has suffered from any other significant illnesses ?
If "yes", please provide details.

10. Is the current treatment related to any of the following? If "yes", please provide full details in the blank space below :

Yes No

a) Routine health screening, vaccination or immunisation purpose

b) Conditions arising out of birth defects, congenital sickness or abnormalities

c) Pregnancy, childbirth, prenatal or postnatal care, miscarriage, abortion, birth control, sterilisation, infertility, sexual dysfunction

d) Depression, mental or functional disorder

e) Sexually transmitted diseases, AIDS or any illness or related to the Human Immunodeficiency Virus (HIV)

11. Is the current condition a result of an accident ?
If "Yes", please describe in detail how the accident happened :

a) Date of accident : _____ (dd/mm/yy)

b) Was the Life Insured under the influence of drugs or alcohol at the time of accident ? Yes/No
If "Yes", please specify type of drugs or level of blood alcohol content :

c) Was a police report made in respect of the accident ? Yes/No
If "Yes", please provide the name of the police station, name of the police officer-in-charge and contact number :

12. Has the Life Insured consulted any other doctors /hospital prior to first consultation with you? Yes/No
If "Yes", please provide the name and address of the doctor /hospital.

DETAILS OF IN-PATIENT TREATMENT (completion of this section is not required if life Insured is treated on an out-patient basis)

1. How was the Life Insured admitted to the hospital ? [please tick]

Referral by a General Practitioner/Specialist/Other Hospital.

Please provide details _____

A&E Department

2. Details of hospitalisation :

Name of Hospital(s)	Period of Hospitalisation		Name of Attending Doctor(s)
	From	To	

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Name and signature of Doctor

Date : Clinic / Hospital stamp

LETTER OF CONSENT

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I,HEREBY GIVE CONSENT

TO

TO APPLY FOR MEDICAL REPORT FOR THE PURPOSE OF

BELOW ARE MY PARTICULARS :

PRESENT ADDRESS :

DATE ADMITTED :

DATE DISCHARGED :

HOSPITAL/WARD :

MEDICAL REG. NO :

I/C NO :

MEDICAL CLAIM FORM

- 1) The Company does not admit liability by the mere issue of this or any other form
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- 3) To be completed by the Life Insured
- 4) Please decide where appropriate

DATE : SIGNATURE

DOCUMENTS REQUIRED TO BE SUBMITTED

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- 2) Original Medical bills
- 3) Medical Report