ايـنـسـورنـس نـاسـيـونـل

National Insurance Company Berhad
(Incorporated in Negara Brunei Darussalam)

Head Office : Units 12 & 13, Block A, Regent Square, Simpang 150, Kampong Kiarong,
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PERSONAL ACCIDENT CLAIM FORM

IMPORTANT NOTES

- Please read the instructions in this claim form carefully and ensure all relevant questions are completed.
- If the space provided is not sufficient, please provide the requested information on a separate sheet and attach it to the claim form.
- Your completed claim form must be submitted to us with original documentations such as receipts, reports, and any that is related to your claims.
- We reserve the right to request for the original receipts, reports or any other supporting documents as and when required.
- If the document is in a foreign language, you are required to provide an English translation at your own expense.
- As each claim is unique, further information may be requested by us.
- If any part of your claim is dishonest or fraudulent in nature, your claim will be denied and we reserve the rights to refer the matter to the appropriate authorities.
- If you do not wish to pursue this claim after your submission please write in to inform us.

The issue of this form is not an admission of liability. It should be completed as fully and accurately as possible and returned immediately.

CLAIMANT DETAILS (All questions in this section must be answered)

Policy No:	**Period of Insurance: From:** **to**
Name of Policyholder(s):	
Name of claimant (Mr/Mrs/Miss/Ms):	**Marital Status:**
NRIC/Passport No:	**Date of Birth:**
Occupation:	**Relationship to Policyholder:**
Address:	
Mobile No:	**Office Tel No:**
Home Tel No:	**Email Address:**

DETAILS OF THE CLAIM:

Please write N/A if it is not applicable for the irrelevant or whole section (s).

ACCIDENT		
1) Date (dd/mm/yyyy):		
2) Is this a job-related accident?	☐ Yes	☐ No
3) Time: am/pm		
4) Please describe fully on how it happened:		
5) Is there injury or damage caused to any person or property?	☐ Yes	☐ No
If you have answered "Yes", please specify and provide details:		
6) State the country and place of treatment:		
7) Please provide the name and address of any person (s) who had witnessed the accident:		
INJURY		
1) Describe the nature and extent of injury sustained:		
2) Have you ever suffered from this injury or similar conditions?	☐ Yes	☐ No
If you have answered "Yes", please specify and provide details:		
3) Are there any further medical bills to be submitted?	☐ Yes	☐ No
4) Has the illness been treated previously?	☐ Yes	☐ No
If you have answered "Yes", please specify and provide details:		

5) Date of first medical consultation:		
6) State the name and address of the doctor:		
7) State name and address of your usual family attending doctor		
8) Did the illness arise from childbirth, miscarriage, pregnancy or any complications? ☐ Yes ☐ No		
If you have answered "Yes", please specify and provide details:		
9) If the insured person was admitted to hospital, please state:		
a) Date of admission:	Time:	am/pm
b) Date of discharge:	Time:	am/pm
DEATH &/OR TOTAL PERMANENT DISABLEMENT (if applicable)		
1) In what capacity are you claiming for the insurance? Please state your relationship to the policyholder.		
2) What is the probable period of disablement?		
3) Please state on when the Insured will be repatriated to the home country (This applies in the event of death or total permanent disablement).		

Please provide us with all of the following documents relating to your claim:

- Medical/hospital/nursing/dental report detailing treatment sought and diagnosis (at the insured's expense)
- Itemized original medical bills and receipts
- Discharge Summary
- Death certificate and burial/cremation permit (in respect of death claim)
- Police report, if applicable
- If hospital benefits is being claimed, please provide a confirmation from hospital on admission and discharge dates
- Funeral expenses (in respect of death claim)
- Written advice by a qualified medical practitioner stating that the person requires assistance, repatriation due to disablement or any other medical aids.
- Incident report from risk premises (in the event of accident or personal liability)
- Letter of Probate or Letter of Administration (in respect of death claim)

DECLARATION

Are there any insurance covering you for the event that is the subject of your claim? ☐ Yes ☐ No

If you have answered "Yes", please provide your policy number and name of the insurance company:

I/We declare that the answers given by me/us in this form are in every respect true and correct and that no material information that is likely to affect this claim has been withheld nor any relevant circumstances omitted. I/we agree to the Company seeking information in connection with this claim from any source and I/we authorize the giving of such information in order to handle my/our claim.

Declared on

Authorized signature and Company's stamp

Signature of Claimant

PAYMENT DETAILS

Please note that payment will be made to you by cheque. Kindly provide us with your details as follows:

Payee / Beneficiary's Name: _____

Payee / Beneficiary's Address: _____

_____

_____

Payee / Beneficiary's Identity No.: _____

MEDICAL CLAIM FORM

To be completed by the patient's Doctor/Dentist (at insured's expense) in all claims resulting from accident, sickness or injury.
Please complete this form in BLOCK LETTERS and provide as much information as possible.

PATIENT'S DETAILS

Name	Date of birth
NRIC/Passport No	Gender
In what country did the treatment take place?	
What is the cause of the illness/injury/death?	
Please provide full details of the symptoms/medical condition requiring treatment	

1) On what date did the patient first present these symptoms to you?

2) On what date would the first onset of symptoms have been apparent to the patient?

3) Has the patient suffered from this condition previously?

☐ Yes ☐ No If yes, when? DD MM YY:

4) Are you aware of any treatment given for this or any related illness in the past? ☐ Yes ☐ No
If yes, please provide details

5) Is it likely to re-occur? ☐ Yes ☐ No
6) Does it need rehabilitation? ☐ Yes ☐ No
7) Is it permanent? ☐ Yes ☐ No
8) Does it need long term monitoring, consultations, checkups, examinations or tests? ☐ Yes ☐ No
If you have answered yes, please provide details:

Please provide name and address of the doctor(s) who had treated the patient previously or referred patient to you:
State how long in your opinion the patient will be disabled to perform his/her normal duty/occupation/business
1) Totally from to
2) Partially from to
Should it be a permanent disablement as per medical report, please state in between 0 - 100 percent pertaining to the affected area suffered by patient at this point in time.

Was the condition of the patient due to the following? (Please tick)

		Yes	No
1	Congenital anomaly or genetic defects present at birth		
2	Study and treatment of sleeping disorder		
3	Dental treatment		
4	Sexually transmitted disease, HIV infection or AIDS		
5	Routine health screening, vaccination or immunization purpose		
6	Functional disorder , depression or mental disorder		
7	Alcoholism		
8	Drug addiction		
9	Cosmetic or plastic surgery		
10	Pregnancy, child birth, infertility , miscarriage, abortion		
11	Self- inflicted injuries		

If you have answered 'Yes' to any of the above, please provide further details:-

Applicable to dental treatment only

Was the patient suffering from sudden dental pain at the time he/she visited you for treatment? ☐ Yes ☐ No

Please provide any other additional information for the Company to assess the claim:

Please provide us with all the following required documents relating to your claim;

- Original medical bills and receipts
- Original medical report
- Discharge Ticket

I hereby certify that the foregoing statements are correct

Signature and stamp of Doctor

Name and address of practicing clinic/hospital

Name of Doctor

Telephone No

Date