eTiQa Takaful

DEATH CLAIM FORM

SECTION A

Section A of this form is to be completed by the claimant who is legally entitled to contract money. Every question must be fully answered. The Company reserves the right to require further information should it deem necessary. Submission of this Claim Form does not guarantee admission of liability.

Contract No _____

Agent's name & code : _____ Agent's Contact No. : _____

Instruction – Supporting documents required

- ☐ Death claim form
- ☐ Death Statement of Medical Examiner (for contract duration < 5 years)
- ☐ Certified copy of Participant and Claimant's IC
- ☐ Certified copy of Death Certificate
- ☐ Certified copy of Burial Certificate
- ☐ Original certificate/policy contract
- ☐ Certified copy of proof of relationship between claimant and participant
- ☐ Certified copy Sijil Faraid / Letter of Administration (if applicable)

Additional requirements on accidental death

- ☐ Detailed Post Mortem report
- ☐ Certified copy of Toxicology report, if any
- ☐ Certified copy of police report
- ☐ Newspaper Cutting, if any

Additional requirements for death in overseas

- ☐ Confirmation letter from National Registration Department (JPN)
- ☐ All relevant documents issued by Foreign Authority must be certified by Malaysia Embassy or Public Notary

DETAILS OF PARTICIPANT

Name of Participant in full _____

New IC No _____ Old IC No. _____ Age _____

Last Address of Participant _____

_____

Name of the Employer of Participant at the time of death _____

Address of the Employer _____

_____

Date of Employment _____ (dd/mm/yyyy) Office Phone No. _____

What family has the Participant left? ☐ Spouse ☐ No.of Child _____ ☐ Parent ☐ Others, please specify _____

DETAILS OF CLAIMANT

Name of Claimant _____

New IC No _____ Old IC No. _____ Age _____

Correspondence Address _____

_____

Mobile Phone No. _____ E-mail address _____

Phone No. _____ Fax No. _____

What is your relationship with the Participant ? _____

Please state your bank account details in order for us to credit the payment directly into your bank account.

Bank : _____ **Account no:** _____

1 Date of death _____ (dd/mm/yyyy) Time _____ (am/pm)

2 Cause of death _____

3 Place of death _____

4 When did Participant **first** complain of or give indication of his / her last illness ? _____ (dd/mm/yyyy)

5 When did Participant **first** consult a Physician for his / her last illness? _____ (dd/mm/yyyy)

6 Name & address of doctor Participant **first** consulted for his / her last illness _____

_____

7 Please state names and address of every physician who attended to the Participant during his / her last illness

Date of consultation (dd/mm/yyyy)	Date of admission (dd/mm/yyyy)	Date of discharge (dd/mm/yyyy)	Diagnosis	Name of doctor & address of hospitals/clinics

8 State the name and address of Participant's regular doctor _____

_____

9 Are there other policies in force on Participant's life taken with other companies ? ☐ Yes ☐ No

If yes, please give details:

Name of Company(s)	Commencement date (dd/mm/yyyy)	Contract no	Type of coverage	Sum assured

10 Death due to accident

a. Date of accident : _____ (dd/mm/yyyy) Time : _____ (am/pm)

b. Place of accident : _____

c. Why was the Participant at the location ? _____

d. Describe in detail how the Accident happened ? _____

_____

e. Was the accident reported to the police? ☐ Yes ☐ No (If yes, please submit a certified copy of police report)

f. Was the accident reported in the newspaper? ☐ Yes ☐ No (If yes, please submit a copy)

g. Was an inquest or post-mortem carried out? ☐ Yes ☐ No (If yes, please submit a certified copy of post mortem report)

DECLARATION

I/We hereby declare that the foregoing answers and statements are complete and true to the best of my/our knowledge and belief, and that I/we have withheld no material facts from the Company.

_____

Signature of Claimant

Full name _____

Contact No _____

Date _____

_____

Signature of Witness

Full Name _____

NRIC No _____

Contact No _____

Date _____

LETTER OF AUTHORISATION / CONSENT
TO OBTAIN FURTHER INFORMATION (DEATH CLAIM)

To Whom It May Concern,

Dear Sir / Madam,

I hereby authorize and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, Insurance company or other organization, institution or individual concerned ("the Information Provider(s)') that may have any records or knowledge of the employment, financial, health or medical history of _____ (name of Participant) and to provide such information to Etiqa Takaful Berhad or its authorized agents and / or employees.

I expressly waive on behalf of myself and / or as a next-of-kin of the Participant and for his / her estate all provisions of law or professional ethics forbidding the Information or (Providers) from disclosing any such information acquired on the Participant in a professional and / or client capacity and I further release the Information Provider(s) and its agent / staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorization / consent is irrevocable and a copy of it will have the same effect and validity as the original.

_____

Signature / Thumb print of Next-of-Kin / Claimant

Name : _____

NRIC: _____

Old IC: _____

Relationship with Participant: _____

Contact No: _____

Date: _____

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