TOKIO MARINE

TOKIO MARINE INSURANS (MALAYSIA) BERHAD

(Co. No. 149520-U)

29th Floor, Menara Dion, 27, Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia.
Tel No: 03-2026 9808, 03 2783 8383 Fax No: 03-2026 9708
Website: www.tokiomarine.com.my

PERSONAL ACCIDENT CLAIM FORM

Claim No._____ Policy No._____ Agency _____

N.B. This form must be completed and returned to the Company within fourteen (14) days after the occurrence of the accident.

1. Name of Claimant/Injured Person in full:

   _____

   Address _____

   _____

   Business or Occupation _____ Date of Birth : _____

   Sex: ☐ Male ☐ Female Age : _____ I.C. No. _____ (Attach Photocopy)

   Tel. No. (H/P) : _____ (Hse): _____ (Off): _____

   Name of Insured/Employer : _____

   Address: _____ Date of Employment: _____

   _____ Tel. No.: _____

2. Date of Accident: _____ Time of Accident: _____

3.	Place/Address where the accident occurred.	
4.	Please describe in detail how the accident occurred and what were you doing at that time.	
5.	Please state as precisely as you can the injuries you have sustained.	
6.	Please give names, addresses and contact no. of any persons who witnessed the accident.	
7.	**Additonal information for motor vehicle accident:**	
	(a) Please state where were you/the Insured Person traveling to and from when the accident occurred.	
	(b) Were you/Insured Person the driver or passenger / pillion rider?	☐ The Driver ☐ Passenger / Pillion
	(c) If you/Insured Person was the driver/main rider, state class of valid licence and expiry date (Please attach a copy of the licence)	☐ Class B ☐ Class D ☐ Class E ☐ _____ Licence Expiry Date : _____ ☐ I have no valid licence
	(d) Any police report lodged ? If no police report made, please state reason(s).	☐ Yes, police report as attached. ☐ No, _____ _____

8.	(a) Please give name and address of Medical Practitioner whom you have first consulted after the accident. (b) Date of the first consultation. (c) Is he your usual physician? If no, please state reason why he was consulted. (d) Please give name and address of all other Medical Practitioners whom you have consulted. (e) Please state reason(s) why different clinic/hospital/ physician was consulted?	(a) (b) (c) (d) (e)
9.	If hospitalized, state the Date and Time of Admission and Discharged	Date Admitted: Time: Date Discharged: Time:
10.	On what date were you able to attend to (a) a portion of your business or occupation (b) the whole of your business or occupation Please attach all original medical chit and a letter from your employer certifying the number of days you were unable to attend work/duty.	(a) (b)
11.	(a) What has been your occupation & duties since the inception of the policy? (b) Has there been any change in your occupation & duties?	(a) (b) ☐ No. ☐ Yes, as stated in (a) above since _____(date)
12.	Have you ever made a claim in respect of any Injury during the last 5 years from any insurance company? If so, please give particulars.	
13.	For this accident, please state all other insurer(s)/source(s) that you are also claiming/entitled to claim.	

14. Please provide details of all Life, Medical, Accident Rider(s) and Personal Accident policies that you have:

Name of Insurance Company	Policy / Claim No.	Sum Insured & Type of Benefit	Have you ever filed a Claim? If yes, please state date of accident

I hereby declare that the above information are true and correct in every aspect and agree that if I have made any false or untrue statement, any concealment, suppression, mis-statement or omission of material fact or if the claim is exaggerated in any manner, my right to the compensation shall be absolutely forfeited.

AUTHORIZATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION

I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I have been observed or treated, to give full particulars about my health including my whole medical history to Tokio Marine Insurans (Malaysia) Bhd.

I further authorize any insurance company and its authorized representatives to release all information and documents pertaining to my policies including all previous and current claim details to Tokio Marine Insurans (Malaysia) Berhad.

A photocopy of this authorization shall have the full effect of the original authorization.

Date

Signature of Insured/Claimant

Company's chop & signature of official, where applicable

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MEDICAL CERTIFICATION

In order to establish his/her Claim, the Claimant must obtain and forward to the Company a Certificate from a duly qualified and registered Medical Practitioner, and it is essential that this Form be filled up as minutely as possible so that the Officers of the Company may properly understand the nature of the case.

1. a) Name of Patient :..... Age .....

   b) Address .....

   .....

   c) Patient Ref. No. ..... IC NO: ..... Occupation: .....

2. a) Name & Address of Referral Doctor: (Please enclose copy of the referral letter) b) Date of Referral:	a) b)
3. a) Date & Time of Accident b) When and where first seen after the accident?	a) Date: Time: b)
4. a) Describe in detail the nature of accident as related to you by the patient. b) Is the injury consistent with the nature of accident as related to you by the patient?	a) b)
5. Describe in detail nature of illness / injury and your diagnosis of the patient's condition.	
6. a) Were there any external and visible injuries seen as a result of this accident? b) If yes, describe the extent of injuries including site and other characteristic features as seen by you.	a) Yes No b)
7. Are the patient's symptoms: a) Due solely to this accident or b) Traceable to disease, infirmity or any other cause? Please provide full details.	a) b)
8. Is the patient now or at the time of the accident sufferring from any illness, disease or infirmity? If so, state the nature and to what extent the recovery has been or may be retarded thereby.	
9. Have you any reason to suppose that he was under the influence of intoxicants at the time of the accident? Please provide full details.	

10. Treatments given including follow-up (such as number of stitches, physiotherapy, tupe of dressing, etc.)

Date(s)	Time (am/pm)	Treatments

Stitches were removed on: _____

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11. Name and address of other physician who treated patient for the same injury:

Date(s)	Address	Approximate duties

12. Did the injuries require any of the following:

a) Hospitalisation ☐ Yes ☐ No Date admitted: _____ Date discharged: _____

Date admitted: _____ Date discharged: _____

b) Surgery ☐ Yes ☐ No Type of surgery performed: _____

c) X-ray / MRI ☐ Yes ☐ No Please enclose a copy of the X-ray / MRI report

13. To what extent the injuries have necessarily disabled the patient from following his/her occupation or giving attention to Business? (All original medical sick leave &/or light duty certificates must be attached for weekly benefit claim).

Patient has been disabled Totally for ..... days From ..... To .....

Partially for ..... days From ..... To .....

TOTAL DISABLEMENT arises when the Claimant is rendered completely incapable of attending to any part of his/her ordinary profession, business or vocation.

PARTIAL DISABLEMENT arises when the Claiman is capable of attending to some portion of his/her ordinary profession, business or vocation.

14. a) Is the patient currently sufferring from any permanent total / permanent partial disablement (loss of use/function) due to the accident? ☐ No. ☐ Yes, 100% Permanent Total Disablement/Total Loss of Use

Yes, Permanent Partial Disablement at _____ % Date of the assessment: _____

b) If yes, please also provide the date of the onset of the Permanent Disablement: _____

c) Detailed description of the Permanent Disablement: _____

_____

_____

_____

d) Date of patient's last visit: _____ e) Date of Next Follow-up, if any: _____

15. REMARKS:

I hereby certify that I have personally examined and treated the Claimant for his/her injuries described above and that the facts as stated above represent my medical opinion of his/her condition.

Name: _____

Qualification: _____ Signature: _____

_____ Tel. No: _____ Date: _____

Hospital/Clinic Stamp

Registration Form

E-Payment

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INSURANCE GROUP

Section A: Personal Details

Account Holder Name: _____

Account Holder Address: _____

Business Registration No (non-individual): _____ GST Registration No.: _____

GST Registration Date: D D M M Y Y Y Y NRIC No./ID No./Passport No. (individual): _____

Telephone No: _____ Handphone No: _____

Contact Person 1: _____ Email: _____

Contact Person 2: _____ Email: _____

Bank Name _____ Bank Code _____ Bank Account Number (please ignore all dashes: '-')

Account Type ☐ Current Account ☐ Saving Account

Other Info ☐ Individual Account ☐ Joint Account

☐ Others
(Support With Relevant Documents)

NRIC No./ID No./Passport No. (individual) for the 1st name

Section B: Declaration

I/We hereby authorize Tokio Marine Insurans (Malaysia) Berhad (TMIM) to credit all monies due to me/us to my/our bank account indicated above by way of Giro Fund Transfer/Rentas and confirm that:

1. I/We hereby declare that the above is my personal account/our company account, and the information given is true and accurate to the best of my/our knowledge and record and I confirm that the account number written under this E-payment form is correct.
2. I/We shall indemnify TMIM for any loss, damage or claims incurred in whatsoever manner as a consequence of acting on such instruction.
3. I/We hereby give my consent to TMIM to disclose my Personal Data to TMIM's service providers and/or financial institutions for the purpose of effecting and administrating the electronic payments (Personal Data includes name, personal identification number, contact details and any other details not specifically mentioned herein).
4. I/We understand that the supply of my Personal Data herein is voluntary and it is necessary for TMIM to process my Personal Data for effecting and administrating the electronic payments to me.

Notice:

Any future changes on the customer personal data, customer are required to write-in to us on the changes. Therefore, kindly provide the email address for the customer to notify the Person In Charge (PIC) to change his/her personal details and email to "letusknow@tokiomarine.com.my".

In the presence of:

Authorised Signatory
Name:
Position:
Date:

***Company/Agency Signatory & Stamp**

**Select where applicable*

****Witness Signatory**
Name:
Date:

***The Witness can be any Third Party*

FOR OFFICE USE ONLY

To be completed by relevant department:

Client Code: _____ Date: D D M M Y Y Y Y

Requestor's Name & Signature/Stamp:

Requestor's Reporting Supervisor Name & Signature/Stamp

Date received: D D M M Y Y Y Y

Created by:
Date:

Verified by:
Date:

Tokio Marine Insurans (Malaysia) Berhad (1149529-U)
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