CRITICAL ILLNESS CLAIM FORM

IMPORTANT NOTICE

- Issuance of this form is not to be construed as an admission of liability on the part of the Company.
- Each question must be answered fully and completely. If insufficient space is provided for your answers, please continue on a separate sheet.
- All claim documents are to be submitted electronically. Kindly keep the original copies for all the documents submitted for a period of 6 (six) years, or longer if so notified by the Company. You will be required to produce the original copies of the said documents if so requested by the Company at any time

PARTICULARS OF INSURANCE		
Policy No	:	
Policy Period	: From	to

INSURED'S PARTICULARS		
Name :		NRIC No :
Address :		
Occupation :		
Tel. No :	Contact Person :	Email :
Claimant's Name(if claimant is a dependant / member of a group policy) :		
Claimant's Occupation & Nature of Work:		Date of Employment: Date of Termination: *(Please provide us your termination letter)*
Is claimant entitled to any claim against Workmen's Compensation benefits / SOCSO / Medical benefits from any other insurer?		☐ Yes ☐ No
If yes, please state Insurance Company and policy details:		

Item	Insurance Company	Policy No	Type Of Policy	Coverage Amount
1				
2				
3				
4				

CLAIMS DETAILS

Please add additional sheet if more than 1 clinic visited

CLINIC DETAILS	
Name of Regular Clinic Visited	
Address of Clinics	
Tel No of Clinic	
Fax No of Clinic	

1. Details of claims and related information:
a) Please name the type of Critical Illness you would like to claim. *Do refer to page 3 and 4 for the full list.*
b) Describe the symptoms and how long have you been having the symptoms
c) Provide the name and address of the doctor who made the diagnosis

CHECKLIST ON THE REQUIRED SUPPORTING DOCUMENTS BY TYPE OF CLAIM

The following checklist will help you assemble the documents required to support your claim

Please note:
i) Please tick against the documents you have submitted
ii) Dependent upon the circumstances, we may require other evidence to support your claim; in which case we will contact you.
iii) Failure to provide the supporting documents may result in a delay of your claim.

Type of Critical Illness	Documents Required
Basic Documents	☐ Duly completed claim form ☐ Copy of NRIC ☐ Copy of Bank Statement
• **Cancer** • **Benign Brain Tumor** • **End-Stage Lung Disease** • **Major Organ / Bone Marrow Transplant**	☐ Biopsy ☐ Cytology Reports/ Histopathological Report (HPE) ☐ T Scans/ MRI ☐ Imaging Studies ☐ Laboratory Evidence ☐ Attending Physician Statement DOWNLOAD *(Please download and to be completed by Attending Physician)* ☐ All other relevant hospital reports that are available
• **Heart Attack** • **Serious Coronary Artery Disease** • **Coronary Artery Disease** • **Coronary Artery By-Pass Surgery** • **Angioplasty and other invasive treatments for coronary artery disease** • **Heart Valve Surgery** • **Surgery to Aorta** • **Primary Pulmonary Arterial Hypertension** • **Cardiomyopathy – of specified severity**	☐ Biopsy ☐ Cytology Reports ☐ CT Scans/ MRI ☐ Imaging Studies ☐ Laboratory Evidence ☐ Attending Physician Statement DOWNLOAD *(Please download and to be completed by Attending Physician)* ☐ All other relevant hospital reports that are available
• **Kidney Failure** • **Systemic Lupus Erythematosus With Severe Kidney Complications**	☐ Biopsy ☐ Cytology Reports ☐ CT Scans/ MRI ☐ Imaging Studies ☐ Laboratory Evidence ☐ Attending Physician Statement DOWNLOAD *(Please download and to be completed by Attending Physician)* ☐ All other relevant hospital reports that are available
• **Stroke**	☐ Biopsy ☐ Cytology Reports ☐ CT Scans/ MRI ☐ Imaging Studies ☐ Laboratory Evidence

	☐ Attending Physician Statement DOWNLOAD *(Please download and to be completed by Attending Physician)* ☐ All other relevant hospital reports that are available
• **Paralysis of limbs** • **Coma** • **Blindness** • **Deafness** • **Third Degree Burns** • **HIV Infection Due To Blood Transfusion** • **Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection** • **Full-blown AIDS** • **End-Stage Lung Disease** • **Encephalitis** • **Loss of Speech** • **Brain Surgery** • **Terminal Illness** • **Loss of Independent Existence** • **Bacterial Meningitis** • **Major Head Trauma** • **Chronic Aplastic Anemia** • **Motor Neuron Disease** • **Parkinson's Disease** • **Alzheimer's Disease/Severe Dementia** • **Muscular Dystrophy** • **Multiple Sclerosis** • **Medullary Cystic Disease**	☐ Biopsy ☐ Cytology Reports ☐ CT Scans/ MRI ☐ Imaging Studies ☐ Laboratory Evidence ☐ Attending Physician Statement DOWNLOAD *(Please download and to be completed by Attending Physician)* ☐ All other relevant hospital reports that are available
• **Diabetic Care Disease**	☐ Laboratory Evidence ☐ Diagnosis Test ☐ Attending Physician Statement DOWNLOAD *(Please download and to be completed by Attending Physician)* ☐ All other relevant hospital reports that are available

Authorization Form to Register for Payment by Direct Credit to Bank Account

I/We hereby authorize Tune Protect Malaysia Berhad (the Company) to credit all my/our payments to my/our bank account indicated below:

1. I/We hereby declare that the information given below is true and accurate to the best of my/our knowledge and records.
2. I/We understand that the Company will rely, and act based on the given information contained herein.
3. I/We shall indemnify the Company and its banker(s) against any loss and/or damage howsoever arising from any matters in relation to Fund Transfer requested by me/us herein including but not limited to error/incorrectness/inaccuracies of the information provided, delayed payment(s) and any other circumstances beyond the control of the Company and/or its banker(s).
4. I/We understand and acknowledge that the Company has the right to collect the/my/our information. By signing the authorization form, I/We consent to the Company using and disclosing my/our personal information for the purpose stated here. I/We also agree to provide information necessary to verify any statement given on this authorization form and to update information promptly to the Company.
5. I/We understand and acknowledge that my/we providing the bank details does not tantamount to the Company having admitted liability towards my/our claim under the relevant insurance policies but is only to facilitate the safe receipt of any monies that is due to me/us.

Account Name (Beneficiary Name)	
Business Registration No. /NRIC	
Bank Name	
Bank Account Number	
Swift Code	
Mobile number	
Email Address	1) 2) 3)

DECLARATION

I/We hereby declare that the above statements and particulars are correct and complete in every respect and I/We have been not concealed, misrepresented or misstated any material fact.

I/We agree that if such statements and particulars are written by any other person, such person shall be deemed to have my/our Agent for the purpose of filling in this form and his statement shall be binding upon me/us

I/We hereby acknowledge and understand the requirements for sharing, processing, retention and amendment by way of the Personal Data Protection Act 2010 and agree to give my fullest co-operation to the Company or its representative in relation to this claim

I/We acknowledge that I/We have accessed and/or read the Privacy Notice of the Company (available at all the Company's branch customer service counters and/or the Company's website) and agree to the processing of my/our personal data in the manner specified therein. I/We also consent to the collection, further processing and disclosure of my/our sensitive details herein for the purpose of processing claims and making the related payments.

I/We understand and agree that any personal information collected or held by the Company (whether contained in this application or otherwise obtained) may be held, used and disclosed by the Company to individuals/organizations related to and associated with the Company and industry associations/federations) for the purposes of processing this application/claim and providing subsequent service for this purpose. I/We understand that I/we have a right to obtain access to and to request correction of any personal information held by the Company concerning me/us. Such request can be made to the Company's Customer Service Center.

Name :	Signature :
Date :	

Authorization To Physician, Hospital Or Clinic To Release Personal Sensitive Information

I hereby authorize any legally registered 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 the Company for the purpose of processing this submitted claim.

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 the Company.

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

Name :	Signature :
Date :	