Level 12, West Wing, The Icon, No. 1, Jalan 1/68F, Jalan Tun Razak, 55000 Kuala Lumpur.
Customer Relationship Centre: 1300 220 007, WhatsApp: 012-6031978, Email: rhbi.general@rhbgroup.com, Website: insurance.rhbgroup.com

PERSONAL ACCIDENT / MEDICAL CLAIM FORM

IMPORTANT NOTICE

Claims notification must be given to **Our** Claims Department within thirty (30) days from the date of any **Occurrence** likely to give rise to a claim in this **Policy**.

Policy No. _____ Claim No. _____

SECTION 1 - DETAILS OF INSURED

Name _____ Address _____

MyKad / Army / Police / Passport / Business Registration No. _____

Nationality _____ Email Address _____ Mobile No. _____ Telephone No. Business _____ Telephone No. House _____

SECTION 2 - DETAILS OF CLAIMANT

Name _____ Address _____

MyKad / MyKid/ Birth Certificate No. /
Army / Police / Passport / Business Registration No. _____

Nationality _____ Date of Birth _____ Relationship _____ Email Address _____ Occupation _____ Mobile No _____ Telephone No. House _____

SECTION 3 - DETAILS OF ACCIDENT

Time and Date of Accident DD ☐☐ MM ☐☐ YYYY ☐☐☐☐ TIME ☐☐ : ☐☐ AM/PM

Location of Accident _____

_____

Cause of Accident _____

_____

_____

Details of injuries sustained _____

_____

Type of sick leave ☐ Medical certificate ☐ Hospitalization

Sick Leave From _____ To _____

Please attach medical certificate

Have you lodged a Police Report? ☐ Yes ☐ No If yes, please provide a copy of police report.

SECTION 4 - ADDITIONAL INFORMATION

Other insurance policy; if any:

Item	Insurance Company	Policy No.	Type of Policy	Period of Insurance	Coverage Amount

Has claim have been filed for Workmen's Compensation/SOCSO? ☐ Yes ☐ No

SECTION 5 - MEDICAL REPORT

NOTE FOR HOSPITAL - Medical Report to be filled up by the treating doctor.

1. Name of Patient

   Sex: Age: Occupation:

2. Hospitalization was recommended by:

3. Name of Hospital or Clinic:

4. Dates of Confinement/Admitted/Treated on: Time: Date of discharge if hospitalised: Time:

5. a. Nature of illness or injury (complete diagnosis)

   b. Is disability arising from patient's employment? ☐ Yes ☐ No

   c. Is disability due to pregnancy/childbirth? ☐ Yes ☐ No

   d. Is disability due to infertility? ☐ Yes ☐ No

   e. Is disease congenital? ☐ Yes ☐ No

   f. Is condition hereditary? ☐ Yes ☐ No

   g. Is condition related to nervous or mental disorder? ☐ Yes ☐ No

   If yes, please specify:

   h. Is condition treated for cosmetic reason? ☐ Yes ☐ No

6. a. Short history of illness or disability

   b. Date you were first consulted DD ☐☐ MM ☐☐ YYYY ☐☐☐☐

   c. Has patient ever had same or similar condition? ☐ Yes ☐ No

   If "yes" please state when DD ☐☐ MM ☐☐ YYYY ☐☐☐☐

   d. How long has this injury or illness been existing prior to consulting you?

   e. Names and address of Doctors previously consulted by patients for the illness.

7. Complete if surgery was performed:

   a. Nature of operation/obstetrical procedure performed:

   b. Name of surgeon:

8. In case of accident please state:

   a. Type of fracture/injury:

   b. Will the injuries sustained result in permanent disability? ☐ Yes ☐ No

   If "yes" please provide details and degree (%) of permanent disability.

9. Kindly complete either:

   a. Is patient totally incapacitated from attending to any part of his/her business/occupation? ☐ Yes ☐ No From _____ To _____

   b. Is patient only partially incapacitated in the sense that he/she is unable to attend to a substantial and essential part of his/her business/occupation? ☐ Yes ☐ No From _____ To _____

10. Remarks, if any:

I hereby certify that the answers above are full, complete and true.

Stamp of Hospital / Clinic

Signature and Stamp of Attending Doctor

Name of Attending Doctor _____

Date _____

SECTION 6 - RHB PRIVACY NOTICE FOR INSURANCE CLAIM FORM

ACKNOWLEDGEMENT AND CONSENT

I have read and understood RHB Insurance Berhad ("RHB") Privacy Notice which has been provided to me at the point of application and which I acknowledge is also available at insurance.rhbgroup.com.

I explicitly consent to RHB processing my personal information (including my sensitive personal information) for the purpose of processing my insurance claim, including any necessary disclosures and overseas transfers of my personal information to relevant third parties, if applicable, subject at all times to any laws (including regulations, standards, guidelines and/or obligations) applicable to RHB.

I also represent and warrant that the consent of third party individuals (e.g. insured/claimant, witnesses, medical practitioner) whose personal information I disclose to RHB has been sufficiently obtained to allow RHB to process the same in relation to the purpose.

[This paragraph is only applicable to parent/legal guardian/next of kin/authorized representative of junior claimant(s)/insured(s), if any]
If you are providing consent as parent/legal guardian/next of kin/authorized representative of the junior claimant/insured whose personal information will be processed as described above, please complete the following information:

Signature : _____

Name : _____

MyKad or Passport No. : _____

Relationship with the junior claimant(s)/insured(s) _____

Signature of Insured / Claimant : _____

Name : _____

MyKad or Passport No. : _____

SECTION 7 - DECLARATION

I/we understand that RHB issuance and acceptance of this form should not be construed as an admission of their liability of my/our claim.

If I/We have given any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be null and void and that I/We shall not be entitled to all/any rights to recover thereunder in respect of any or all claims, past, present or future and my / our claim shall be absolutely forfeited.

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

I/We hereby agree to give my/our fullest cooperation to RHB or its authorized representative in relation to this claim.

I/We understand that the above questions shall not prejudice RHB general rights to raise any other questions related to the claim.

I/We hereby authorise any hospital, physician or other persons who have attended to or examined me to furnish to the Company or its authorised representative, any information in respect of this injury and/or my previous medical history consultation or treatment and copies of all hospital or medical records. A photostat copy of this authorisation should be considered effective and valid as the original.

Signature of Insured / claimant and company stamp (if applicable) : _____

Name : _____

MyKad or Passport No. : _____

Date: _____

SECTION 8 - E-PAYMENT REGISTRATION FORM

In the event of claims payment, kindly fill up details below for payment processing.

PART I. BENEFICIARY DETAILS

Name of Applicant / Company _____

MyKad No. / Co. Registration No. _____

Address _____

_____

Telephone No. _____ Fax No. _____

Person In-Charge Name 1) _____ 2) _____

Email Address 1) _____ 2) _____

Telephone No. 1) _____ 2) _____

PART II. BENEFICIARY BANKING DETAILS

Name of bank _____

Bank Address _____

Bank Account No. _____ SWIFT Code _____

IBAN Code (if applicable) _____

PART III. DECLARATION

I/We hereby request that payment(s) due to me/us by RHB Insurance Bhd be paid to my/our bank account stated above by way of Inter-bank Giro/RENTAS/TT and confirm that :

I/We consent to RHB Insurance Berhad releasing the above data to its banker(s) in order to facilitate payment(s) to me/us by way of Inter-bank Giro/RENTAS/TT.

All information provided herein are correct and accurate.

My/Our request herein shall be irrecoverable without the consent of RHB Insurance Berhad. RHB Insurance Berhad may at any time in its absolute discretion effect payment(s) to me/us by other mode(s).

I/We shall keep RHB Insurance Berhad and its banker(s) indemnified against any loss and/or damage howsoever arising from any matters in relation to Inter-bank Giro/RENTAS/TT requested by me/us herein including but not limited to error/mis-description in information furnished, delayed payment(s) and any other circumstances beyond RHB Insurance Berhad and its banker(s)'s control.

_____ _____

Authorised Signatory(ies) Company stamp

Name : _____ Date: _____

Designation: _____

PART IV. RHB INSURANCE BERHAD OFFICE USE ONLY

Department Branch:		
Profile:	☐ Agent ☐ Workshop ☐ Adjuster ☐ Vendor ☐ Other, please specify	
Agent / Workshop / Adjuster / Vendor Code		
Entered by:		Date:
Verified by:		Date:

* Important
This facility allows payment to be credited into the above mentioned account only.
Please attach (i) copy of MyKad or Passport or Business Registration Form whichever is applicable and (ii) 1st page of (a) your bank statement; or (b) your bank saving book showing the account name and account number; or (c) details of your bank account obtained from your bank's website that has been certified by your bank; or (d) letter from your bank confirming your bank account details.