هوڠ ليوڠ م.س.أ.ج. تكافل
HongLeong MSIG Takaful

Group Hospital & Surgical Claims Form (EMGS)

Document	Benefits			
	Outpatient Claims	Inpatient Claims	Reimbursement of Tution Fee	Compasionate Visitation Benefit
HLM Takaful Claims Form Section 1	☐	☐	☐	☐
HLM Takaful Claims Form Section 2		☐		
Original Bill & Receipt	☐	☐		
Itemised Bill	☐	☐		
Referral Letter from Panel Clinic (For Specialist Visit)	☐		☐	
A copy of Passport	☐	☐	☐	
Copy of passbook / copy of account bank	☐	☐	☐	☐
Official receipt of tuition fee on uncompleted academic session			☐	
College / University to confirm the clasess were dropped / withdrawn			☐	
Report from doctor on the recommended period of Covered Member not fit on attending his/her academic session			☐	
Recommendation letter from doctor on the necessity for medical evacuation (in the event of emergency medical evacuation)				
Official receipt of transportation and accomodation				☐
Report from doctor comfirming medical condition of the Covered Member is not allowed for repatriation and period of stay in hospital				☐

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Claims No :

Type of Claim

☐ Hospitalisation ☐ Pre/Post Hospitalisation ☐ Reimbursement of Tution Fees ☐ Compasionate Visitation Benefit

Section I - To be completed by the participant **Participant Information**		
1. Name of Participant (as in NRIC / Passport No)		
2. I/C No / Passport No	3. Date of Birth	4. Certificate No
5. Join Date	6. Plan	7. Appication No
8. Address (Co- Respondance Address)		
9. Telephone No : Mobile No	Office No	
10. E-mail Address		
11. Bank Name	12. Account No	
Patient Information *(if other than Participant)*		
1. Name of Patient (as in NRIC / Passport No)		
2. I/C No / Passport No	3. Date of Birth (dd/mm/yyyy)	
4. Claimant is ☐ Self ☐ Spouse ☐ Child		
For Accidental Cause Only		
1. Date of Event (dd/mm/yyyy)	2. Time	
3. Full circumstances of the accident		
4. Describe the type of injuries sustained		
For Illness Cause Only		
1. Describe the symptoms		
2. Date first began		
3. Duration of symptoms prior hospitalization	4. Final Diagnosis	
Details of Other Insurance Policies, Takaful Certificate		
1. Policy Type/Plan:	2. Policy No / Certificated No:	
3. Insurance Company / Takaful Operator		

Authorisation to Physician, Hospital or Clinic to Release Information

I hereby declare that all information provided in this form is complete and true. I hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I/claimant have been observed or treated to give full particular about my/claimant's health including my/claimant's whole medical history in respect of this hospitalisation/surgery to Hong Leong MSIG Takaful Berhad. A photocopy of this authorisation shall be considered as effective and valid as the original. I understand that this information will be kept strictly confidential by Hong Leong MSIG Takaful and that Hong Leong Takaful undertakes not to disclose this information this information to any third party without my separate written consent.

I agree and authorise Hong Leong MSIG Takaful Berhad to firstly offset any existing indebtedness/claims shortfall incurred by myself and/or family members, against payable claims (if any) arising from this submission

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Signature of Participant/ Claimaint

Date

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Section II – To be completed by the Attending Doctor

Name of Patient

NRIC / Passport No	Date of Admission	Date of Discharge

Name of Referring Doctor and Address

Admitting Doctor	Attending Doctors	Specialty

Symptoms/ Condition Requiring Admission	Date First Appeared

Any previous consultation/ treatment/hospitalization for any this symptom/illness or related condition

Date	Disease/Disorder	Details of Teatment/Hospitalisation	Doctor/Hospital

1a) Diagnosis/ICD Coding
I)
II)
III)

1b) Cause and Pathlogy (if Applicable) of the above diagnosis

5) Was the illness/condition related to (Please tick √ if YES)

a) ☐ Pregnancy __________weeks
b) ☐ Congenital/Hereditary Disease
c) ☐ Psychotic /Nervous Disorder/ Mental/Emotional
d) ☐ Cosmetic Reason / Plastic Surgery
e) ☐ Dental Care/Reactive errors Correction
f) ☐ Suicide/ Self –Inflicted Injuries
g) ☐ Childbirth/Fertility
h) ☐ Violation of Laws/Strike/Riots

2a) When did patient first consult you for this condition?

2b) Was the patient previously treated for this condition by yourself or by other medical practitioner?

☐ No
☐ Yes, give details and when

6a) Is the hospitalization /treatment medically necessary ?

☐ No ☐ Yes, please give the details

6b) Is it possible to provide this treatment on an outpatient basis?

☐ No ☐ Yes, please give the details

3) Any possibility of Relapsed?

☐ Yes ☐ No

7) Did any complications arise during hospitalization?

☐ No ☐ Yes, please give the details

4a) Please √ Nature of Treatment and Invstigation

☐ Operation ☐ Physiotherapy ☐ Diatary Counselling
☐ Medication ☐ X-ray ☐ Blood Test

4b) Please state type of Procedure/Surgery performed

Type	Surgical Code	Date	Name of Doctor
i)			
ii)			
iii)			

4c) Other medical condition present?

8) Was the patient pregnant at the time of hospitalization? (for female only)

☐ No ☐ Yes,_____________months

9) If the hospitalization was due to accident, please indicate date of accident

Discharge / follow up instructions

Singature and Name of Attending Doctor | Hospital Stamp | Date