PERSONAL ACCIDENT AND HEALTH CLAIM FORM

This form must be completed truthfully and accurately. If the space is not enough or no applicable field available, please supplement information by attachment. The list of documents required is not exhaustive and we reserve the right to request from you any additional information/documentation, as necessary.The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned to us together with all supporting documents as soon as possible at the following address

AIG Malaysia Insurance Berhad (795492-W)
Claims Department, Level 16
Menara Worldwide, 198 Jalan Bukit Bintang,
55100 Kuala Lumpur, Malaysia
Telephone : 1 800 88 8811
Facsimile : 603 2685 4896
Email address: AIGMYCare@aig.com
www.aig.my

Section I – General Information (REQUIRED)

Policy/Certificate No. :	Name of Policyholder (as per NRIC / Certificate of Incorporation) :	
Name of Insured (as per NRIC / Certificate of Incorporation) :		Insured's NRIC No/Passport No. :
Name of Claimant (as per NRIC /Certificate of Incorporation) : (Only applicable for fatal case)	Claimant's NRIC No./Passport No. :	Relationship between Claimant & Insured :
Name of Parent/Legal Guardian (Only applicable if the Insured is below the age of 18) :		Parent/Legal Guardian's NRIC No. /Passport No. :
Claimant's E-mail Address:	Claimant's Mobile Phone No. : Acknowledgement will be sent to this mobile phone number via SMS upon receipt of this form.	Insured's Occupation :
Mailing Address :		
Are you a citizen of the United States? ☐ Yes ☐ No	If yes, please provide your social security number :	

AIG Malaysia Insurance Berhad (795492-W) is a subsidiary of U.S. company and as such is required to report injury claims of U.S. citizens who may be eligible to receive "Medicare" (pursuant to the Medicare, Medicaid & SCHIP Extension Act of 2007). This information is requested solely to enable us to comply with this reporting requirement.

Claim Type (please tick) : ☐ New Claim ☐ Further Claim, with Claim Number : _____

Claim Item (please tick) :

☐ Outpatient Medical Expense ☐ Critical Illness ☐ Broken Bone ☐ Weekly Indemnity
☐ Hospital Income ☐ Permanent Disability ☐ Other, please specify :
Amount RM _____ ☐ Hospital Expenses ☐ Accidental Death _____

Do you have any other insurance policies covering this loss or expenses incurred?

☐ Yes ☐ No

If yes, please provide the details below

Name of Insurer : _____

Policy No. : _____ Policy Type : _____ Sum Insured : _____

Bank Details for E-Payment

Account Holder's Name (Must be the Insured or Insured's Parent/ Legal Guardian if the Insured is below the age of 18) :	Bank Name :
E-mail Address (if different from above) : Notification of payment will be sent to this email address	Account Number :

Documents Required for Submission of Your Claim

Outpatient Medical Expenses :
- Original receipt(s) with proof of diagnosis

Hospital Income
- Hospital Billing Statement
- Completion of Claim Form Section IV by the treating doctor
- All relevant medical and examination report

Hospital Expenses
- Original hospital bills and receipts
- Completion of Claim Form Section IV by the treating doctor
- All relevant medical and examination report

Weekly Indemnity
- Copy of Medical Sick Leave (MC)
- Completion of Claim Form Section IV by the treating doctor
- Copy of police report (if related to motor vehicle accident)
- Driver's driving license, if the Insured was driving at the time of accident

Broken Bones
- Broken Bones Medical Report form completed by treating doctor
- All relevant medical and examination report

Accidental Death & Disablement :
- Police report , if applicable
- Driver's driving license, if the insured was driving at the time of accident
- Documentary proof certifying the insured is suffering from permanent disability
- Copy of death certificate (applicable for death claim)
- Detailed post- mortem report (applicable for death claim)
- Grant of Probate / Letters of Administration (if no nominee is stated in the policy)

Critical Illness:
- Completion of Claim Form Section IV by the treating doctor
- All relevant medical and examination reports regarding the claimed Critical Illness
- Histopathology Report (applicable to cancer)

If the medical expenses were claimed from another Insurer organization , please provide their claim settlement letter.
If the Insured is a child, please provide proof of relationship such as copy of birth certificate.

Section II – Details of Injury / Sickness / Incident

Date and time of the injury/sickness/Incident : DD MM YYYY ☐ A.M. / ☐ P.M.	Date of first consultation with doctor/hospital : DD MM YYYY	Nature of injury/Diagnosis of sickness/Incident :
In the case of injury, where and how did the accident occur? In the case of sickness, what were the symptom(s) and when did the symptom(s) first appear?		
Part of body affected :	Name of the attending doctor :	Address of where the patient is treated :
Name of Witness(es) (Applicable to Injury Claim) :	Address of witness(es) (Applicable to Injury Claim) :	Contact number of witness(es) (Applicable to Injury Claim)
Was the injury due to any other person's fault? ☐ Yes ☐ No	If yes, please provide name, address and contact number of this third party(s):	
Did this accident occur in the course of and/or arising out of employment? ☐ Yes ☐ No	If yes, please state the name of the insurance company for Workmen's Compensation Insurance and the Policy no.	Period of sick leave granted by attending physician From DD MM YYYY To DD MM YYYY
Do you need to receive further medical treatment? ☐ Yes ☐ No	If yes, how long will the further medical treatment last?	

Section III – Declaration and Authorization

COMPANY DECLARATION (for Group Policy only)

I/ We hereby certify that _____ is/my our employee effective from _____ and is currently holding the position of _____

If no longer under employment, please advice the last date of employement:

Day - Month - Year

SCHOOL / KINDERGARTEN DECLARATION

I/ We hereby certify that _____ is currently a student of my/our school/kindergarten.

Authorised signature of company/school/kindergarten
(Please also affix company/school kindergarten rubber stamp)

_____
Name/Designation

Date Signed Day - Month - Year

DECLARATION AND AUTHORIZATION

I/We do solemnly declare that the forgoing particulars are true and correct in every detail. I/We agree that if I/we have made,or, in any further declaration in respect of the said claim, if I/we shall make any false or fraudulent statements or suppress, omit to disclose, or falsely state any material fact whatsoever, this claim shall be voided and all rights of recovery in connection with this claim shall be forfeited.

I/We hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I/my ward have/has been observed or treated, to give full particulars about my/my ward's health including my/my ward's whole medical. history in respect of this hospitalization/surgery to AIG Malaysia.

I/We declare and confirm that all information provided are full , complete , true and accurate. I hereby authorize AIG Malaysia to release payment via direct credit or GIRO to the above Bank Account . I further understand that AIG Malaysia relies on the above information and instruction in order to make payment and in the event of any loss arising from this payment , AIG Malaysia is absolved from any or all liability.

_____
Signature of Claimant

_____
Signature of Policy Holder/ Insured Person and Company Rubber Stamp

Date Signed Day - Month - Year

For all intents and purposes where there is a conflict or ambiguity as to the meaning in the English provisions or the Bahasa Malaysia provisions, it is hereby agreed that the English version will prevail.

Section IV-Attending Physician Statement (Applicable to Hospital Income,Hospital Expense and Critical Illness Claims Only)

Patient's Information

Name :	Age:	NRIC No. / Passport No :

Patient's Medical History

Date of injury occurred or symptom(s) first appeared :	Date of first consultation with you :	Was the patient referred by any other doctor or hospital?
DD MM YYYY	DD MM YYYY	If yes, please state name of the doctor and hospital : ☐ Yes ☐ No
Diagnosis :		Date of first consultation with referring doctor DD MM YYYY

To the best of your knowledge, has the patient ever had the same or similar condition(s) or symptom(s)?	Was the condition caused by any underlying disease?
☐ Yes ☐ No If yes, please state dates and conditions / symptoms :	If yes, please specify : ☐ Yes ☐ No

Is the diagnosis due to or associated with any of the following?

(a) Congenital anomalies?	☐ Yes	☐ No	(e) Refractive error or correction of eyesight?	☐ Yes	☐ No
(b) Heredity condition?	☐ Yes	☐ No	(f) Cosmetic or plastic surgery?	☐ Yes	☐ No
(c) Pregnancy or childbirth?	☐ Yes	☐ No	(g) Routine medical check-up?	☐ Yes	☐ No
(d) Drugs or alcohol?	☐ Yes	☐ No	(h) Mental or nervous disorders?	☐ Yes	☐ No

Name of hospital :	Date of admission :	Date of discharge :
	DD MM YYYY	DD MM YYYY

Major complaints of the patient :

In the case of injury, were the patient's complaints solely caused by this current accident? If not, is there any connection with a previous accident or any other causes? Please specify.

Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow-up plan) :

If the patient had a surgical procedure, please fill in the boxes below. :

Name and nature of the procedure :	Date of the operation :
	DD MM YYYY

Declaration

I hereby certify that the facts given above are true to the best of my knowledge.

Signature and stamp :	Name of attending physician/specialist :	Date :
		DD MM YYYY
Qualifications :	Telephone no. :	Hospital :