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

WORKMEN'S COMPENSATION CLAIM FORM

Policy No. | Claim No.

SECTION 1 - DETAILS OF INSURED

Name | Address

MyKad/Army/Police/Passport/Company Registration No.

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

SECTION 2 - DETAILS OF CLAIMANT / THIRD PARTY

Name | Address

MyKad/Army/Police/Passport/Company Registration No.

Nationality | Email Address | Mobile No. | Telephone No. (Business) | Telephone No. (House)

SECTION 3 - DETAILS OF LOSS / DAMAGE / ACCIDENT

Time and date of loss / damage / accident — Date ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time ☐ : ☐ AM/PM

Location of loss / damage / accident

Cause of loss / damage / accident

Have you lodged a Police Report? ☐ Yes ☐ No

SECTION 4 - ADDITIONAL INFORMATION

No.	Description of items / Injury / Treatment / Claim	Name and address of Hospital / Clinic	Amount of Claim

Note: The claims examiner will liaise with you should they need more information on your claims application.

SECTION 5 - 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 No.

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

Signature :

Name/Nama :

MyKad/PP No. :

SECTION 6 - 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.

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

Name

MyKad No.

Date

SECTION 7 - 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.

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MEDICAL CERTIFICATE

WORKMEN'S COMPENSATION CLAIM

(For completion of form see notes on page 5)

This form to be completed and certified by the attending Medical Officer/Practitioner

Name : _____ Sex : _____

Occupation : _____ MyKad/Passport No. : _____

I, the undersigned Medical Officer/Practitioner, understand that the above claimant is making a claim for compensation under Workman Compensation Claim and having examined the said claimant, I hereby certify that :

1. To the best of my belief the claimant is _____ years of age.
2. The claimant is suffering from the following disease of disability.

_____

_____

3. In my opinion the claimant has sustained the following degree of disablement as a result of the accident or occupation :

i. Total Temporary Disablement which is estimated to last from _____ to _____
ii. Partial Temporary Disablement which is estimated to last from _____ to _____
iii. No Permanent Disablement from _____
iv. Total Permanent Disablement from _____
v. Partial Permanent Disablement as listed in the First Ordinance (See Note 1)

_____

vi. Partial Permanent Disablement in the form of physical impairment described hereunder

_____

_____

as a result of which the claimant will not be able to accept employment in occupation which (See Note 2)

_____

_____

_____

Name : _____ Signature & Rubber Stamp : _____

Qualification : _____

Date : _____

NOTES :

Note 1. If Section 3(v) is completed the following are the injuries deemed to result in permanent partial disablement under the First Schedule

	INJURY	**MINIMUM PERCENTAGE OF LOSS OF EARNING CAPACITY**
a.	Loss of arm above or at the elbow	70%
b.	Loss of arm below the elbow	60%
c.	Loss of leg above or at the knee	60%
d.	Loss of leg below the knee	50%
e.	Permanent total loss of hearing	50%
f.	Loss of thumb	25%
g.	Permanent total loss of hearing in one ear	20%
h.	Loss of sight of one eye	30%
i.	Loss of one phalanx thumb	10%
j.	Loss of index finger	10%
k.	Loss of any finger other than index finger	5%
l.	Loss of great toe	10%
m.	Loss of all toes on one foot	20%

Note 2. The following are examples of broad type of occupation for which in your opinion, the claimant is deemed to be unfit :

a. Involve long period of standing
b. Involve lifting of heavy weights
c. Require acute unimpaired perspective version
d. Involve working below ground
e. Involve working on ladders or scaffolding