Serial No.: **H&S /**

RHB INSURANCE BERHAD (Co. No. 38000-U)

LEVEL 12, WEST WING, THE ICON, NO.1, JALAN 1/68F, JALAN TUN RAZAK, 55000 KUALA LUMPUR
TEL: 03-2180 3000 / 2180 3200 FAX: 03-2161 6322 (Claims)

CLAIM FORM - ☐ RHB CREDIT CARD HOSPITAL CASH PLAN ☐ HOSPITALISATION & SURGICAL MEDICAL BENEFITS

INSTRUCTION

1. This form and Medical Report overleaf must be fully completed to avoid any delay in the settlement of claim.
2. Please furnished a copy of medical bill to expediate settlement of claim.
3. If the patients is a child, the parent/insured should sign the statement of consent. Birth certificate of child must be produced.

SECTION 1 - TO BE COMPLETED BY THE INSURED

1. Policy No. : Period of Insurance :	Claim No. : Insurance Plan of Claimant : Date of Appointment:
2. Name of Insured / Member : Occupation :	Date of Birth : Race : Hospital in Patient Card No. :

SECTION 2 - TO BE COMPLETED IF CLAIM MADE FOR INSURED DEPENDENT

☐ Spouse Name :	Date of Marriage :
☐ Son / Daughter Name :	Date of Birth :

SECTION 3 - ACCIDENT (PLEASE OMIT IF NOT APPLICABLE)

1. Date :	2. Time :
3. Place :	
4. At Work : ☐ Yes ☐ No	
5. State how it happened :	

SECTION 4 - SICKNESS (PLEASE OMIT IF NOT APPLICABLE)

1. Name of Illness :	Date first Discovered :
2. Has this condition been treated previously? ☐ Yes ☐ No	Date first Treated / Consulted :
If "Yes" state name of Doctor, Hospital and Address.	

SECTION 5 - OTHER INFORMATION (TO BE COMPLETED FOR ANY CASES)

1. Name & Address of Hospital / Clinic :	
2. Date Admitted / Treated :	3. Date Discharged, if hospitalised :
4. Date Surgery Performed :	
5. Sick Leave : From to	No. of days : (Please attach medical certificates)

SECTION 6 - ONLY APPLICABLE FOR HOSPITALIZATION & SURGICAL CLAIM

1. Has claim been field for Workmen's Compensation / SOCSO? Will such claim be field?	☐ Yes ☐ No ☐ Yes ☐ No
2. Claim cheques should be made payable to :	☐ Hospital ☐ Doctor ☐ Employer ☐ Employee

SECTION 7 - STATEMENT OF CONSENT BY THE PATIENT / PARENT / EMPLOYEE

I hereby authorize any physician, or any hospital who has attended me / my child to furnish or disclose all known facts concerning this disability to RHB Insurance Berhad. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of patient / Parent / Employee ______________________ I/C No. ________________ Dated ____________

Signature of Insured ____ Dated ________________

HSNC1/011099

MEDICAL REPORT

NOTE FOR HOSPITAL - To expedite settlement of the claim, please answer all questions here in.

PART II

1. Name of Patient : Sex : Age :	2. Hospitalization was recommended by :
3. Name of Hospital :	
4. Dates of Confinement : Admitted on : Time :	Discharged on : Time :
5. a. Nature of sickness or injury (complete diagnosis)	
b. Is disability arising from patients employment?	
c. Is disability due to pregnancy/childbirth?	
d. If "Yes" what was the approximate date of commencement of pregnancy?	
e. Is disability due to infertility?	
f. Is disease congenital?	
g. Is condition hereditary?	
h. Is condition related to nervous or mental disorder? If yes, please specify :	
i. Is condition treated for cosmetic reason?	
6. a. Short history of illness or disability	
b. Date you were first consulted	
c. Has patient ever had same or similar condition	
d. If "yes" please state when	
e. How long has this injury or sickness been existing prior to consulting you?	
f. 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 : Please check where applicable : Operation is ☐ Major ☐ Med ☐ Minor	
b. Name of surgeon :	
8. In case of accident please state : a. Type of fracture : b. Nature of treatment :	
9. Remarks, if any :	

I hereby certify that the answers above are full, complete and true.
State Name and address of Physician

Signature and Stamp ____________________

Stamp of Hospital ____________________ Date : ____________________

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