8. KINDLY COMPLETE EITHER : (a) Is he/she totally incapacitated from attending to any part of his/her business/occupation?	(a) ☐ Yes ☐ No Date of commencement _____ Date of cessation of total incapacity _____
(b) Is he/she only partially incapacitated in the sense that he/she is unable to attend to a substantial and essential part of his/her business/occupation? **OR**	(b) ☐ Yes ☐ No Date of commencement _____ Date of cessation of partial incapacity _____
(c) Please state period the patient is confined in Hospital or Nursing Home	(c) From _____ To _____
(d) Please state period the patient is confined at Home	(d) From _____ To _____
9. (a) Will the injuries sustained result in permanent disability?	(a) ☐ Yes ☐ No
(b) If 'Yes', please provide details and the degree (%) of permanent disability.	(b)
10. Any further remarks?	

I hereby certify that the above are consistent with the accident referred to any that my foregoing statements and answers are correct to the best of my knowledge and belief.

DATED THIS _____ DAY OF _____ 20 _____

_____
Stamp of Hospital/Clinic:

Signature/Company Chop _____

Qualifications _____

Address _____

_____

_____

_____

Serial No.: **PA /**

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 - PERSONAL ACCIDENT

Applicable to all Personal Accident Class except Hospital & Surgical, Hospital Cash Plan & Travel Insurance

N.B. TO ENABLE THE COMPANY TO SETTLE THE CLAIM QUICKLY, BOTH CLAIM FORM AND DOCTOR'S CERTIFICATE (MEDICAL REPORT) MUST BE COMPLETED AND RETURNED IMMEDIATELY. HOWEVER, IF THE DOCTOR'S CERTIFICATE COULD NOT BE SUBMITTED IMMEDIATELY, YOU MAY SUBMIT THE CLAIM FORM TO THE COMPANY FIRST.

This form is issued without any admission of liability and it must be returned to the Company duly completed within 14 days after the accident.

Claim No. : _____

SECTION 1 - INSURED INFORMATION

1. Policy Number	
2. (a) Name of Insured (in full) (b) Age (c) Business/Occupation	(a) (b) (c)
3. (a) Address (b) Telephone Number	(a) (a)
4. (a) When did the accident occur? (b) Where did it occur?	(a) Date : Time : am/pm (b)
5. Name of Claimant.	
6. Please describe fully how the accident occurred.	
7. Particulars of injuries sustained.	
8. Names and addresses of witnesses.	
9. (a) Please state name and address of doctor in attendance. (b) Is he your usual doctor? (c) If 'No' please state name and address of your usual doctor.	(a) (b) ☐ Yes ☐ No (c)

10. (a) How long have you been totally incapacitated from attending to any part of your occupation?	(a) From _____ To _____
(b) How long have you been partially incapacitated in the sense of being unable to attend to a substantial and essential part of your occupation?	(b) From _____ To _____
OR	
(c) Please state period you are confined in Hospital	(c) From _____ To _____
(d) Please state period you are confined at Home	(d) From _____ To _____
11. (a) Are you insured elsewhere under a Personal Accident Policy?	(a) ☐ Yes ☐ No
(b) If 'Yes', please state name of Insurers and their policy numbers.	(b)

I hereby declare that the above statement are true to the best of my knowledge and agree that if I have made or if I shall make any false or untrue statement suppression of concealment my right to compensation shall be absolutely forfeited.

I and the Claimant 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.

DATED THIS _____ DAY OF _____

Signature of Claimant _____

NRIC No/Birth Certificate _____

P/s : If the Insured and claimant are the same person, one signature only required.

SECTION 2 - MEDICAL REPORT

MEDICAL REPORT

(Private and Confidential)

NOTE TO MEDICAL PRACTITIONER : Please complete this form as fully as possible. The information provided by you in this form will enable us to calculate the benefits payable under the Policy. We rely on your integrity and professionalism in ensuring that the period of disability stated for both Temporary Total Disablement and Temporary Partial Disablement represents a true assessment of the period which the claimant should be away from work as a result of the injuries sustained. All claim forms are submitted to our Company's Doctors for approval.

1. Name of patient	
2. Occupation of patient	
3. When did he/she first consult you about this condition?	
4. Please give details of injuries sustained	
5. Please state the cause of the injuries	
6. (a) Has he/she any illness or disease or physical infirmity apart from the condition mentioned above?	(a) ☐ Yes ☐ No
(b) If 'Yes', please give details and indicate whether it will retard recovery?	(b)
7. (a) Is patient still under your care for this condition?	(a) ☐ Yes ☐ No
(b) If 'No', please state date of termination.	(b)