

**Seksyen I - Untuk diisi oleh Pekerja/ Pesakit (DALAM HURUF BESAR) & diserahkan kepada ING untuk tuntutan.
Section I - To be completed by the Employee/ Patient (IN BLOCK LETTERS) for submission to ING for claim processing.**

MAKLUMAT PEKERJA EMPLOYEE INFORMATION

Nama Pekerja (seperti di dalam KP) Name of Employee (as in IC)

 No. Kad Pengenalan Pekerja Employee NRIC No. _____
 No. Polisi Policy No. _____
 Pekerjaan Occupation _____
 No. Tel Tel No. _____
 Nama Syarikat/ Majikan Name of Company/ Employer

Employer's Signature,
Stamp & Address
Tandatangan, Chop
Rasmi & Alamat
Majikan

MAKLUMAT PESAKIT/PIHAK MENUNTUT PATIENT/CLAIMANT INFORMATION

Nama Pesakit (selain daripada Pihak Diinsuranskan)
Name of Patient (other than the Insured) _____
 No. Kad Rawatan (Pesakit) Member ID Card No. (Patient) _____
 Tarikh Lahir Pesakit / Pihak Menuntut Birth Date of Patient / Claimant
 [d d m m y y y y] - [d d m m y y y y]
 Tarikh Cuti Sakit Date of MC [d d m m y y y y] - [d d m m y y y y]
 Jumlah Hari Cuti Sakit No. of MC Days [] []

Perhubungan dengan Pekerja Relationship to Employee
 Diri Sendiri Self
 Suami/Isteri Spouse
 Anak Child
 Jantina Pihak Menuntut Gender of Claimant
 Lelaki Male
 Perempuan Female

JENIS TUNTUTAN TYPE OF CLAIM

Kemasukkan ke Hospital Hospitalisation
 Jenis Penyakit/ Kecederaan Nature of Illness/ Injury _____
 Pesakit Luar Outpatient
 Jenis Penyakit/ Kecederaan Nature of Illness/ Injury _____
 Kemalangan Accident
 Tarikh & Masa Kemalangan Date & Time of Accident _____
 Jelaskan bagaimana ia berlaku State how did it happen _____

**BUTIR-BUTIR INSURAN LAIN, PERKESO, INSURANS PAMPASAN PEKERJA DAN LAIN-LAIN
DETAILS OF OTHER INSURANCE POLICIES, SOCSO, WORKMEN'S COMPENSATION AND OTHERS**

Jenis Polisi Policy Type _____ No Policy Policy No. _____
 Syarikat Insuran Insurance Company _____

MAKLUMAT PEMBAYARAN PAYMENT DETAILS

Pembayaran Tuntutan hendaklah dibayar kepada Payment of Claim is to be made to
 Syarikat Company Pekerja Employee Hospital Medical Centre

**MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT
AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION**

Saya dengan ini mengesahkan bahawa semua maklumat yang diberikan di dalam borang tuntutan ini adalah benar dan lengkap. Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya/pihak menuntut untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya/pihak menuntut termasuk latarbelakang penuh perubatan saya/pihak menuntut semasa dimasukkan di hospital/menjalani pembedahan kepada ING Insurance Berhad. Salinan surat kebenaran ini adalah dianggap sah dan berkuatkuasa sebagaimana salinan asal. Saya faham bahawa maklumat ini akan dianggap sulit oleh ING Insurance Berhad dan ING Insurance Berhad tidak akan melepaskan maklumat ini kepada sesiapa tanpa kebenaran bertulis dari saya. Semua maklumat yang diberikan adalah benar dan tepat.
 I hereby declared that the above information given in this claim form is complete and true. I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I/claimant have been observed or treated, to give full particulars about my/claimant's health including my/claimant's whole medical history in respect of this hospitalisation/surgery, to ING Insurance 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 ING Insurance Berhad and that ING Insurance Berhad undertakes not to disclose this information to any third party without my separate written consent. All information provided is true and accurate.

Tandatangan Pekerja / Pihak Menuntut
Signature of Employee / Claimant

Tandatangan Pekerja / Pihak yang Diinsuranskan
Signature of Employee / Insured

Tarikh
Date

SECTION II - Discharge Medical Report Form**To be completed by the Attending Doctor (IN BLOCK LETTERS)****MNR No:**

Name of Hospital and Address

Name of Patient

NRIC No

Date and Time of Admission

 (dd) (mm) (yy) (hrs)

Date and Time of Discharge

 (dd) (mm) (yy) (hrs)

Name of Referring Doctor and Address

Admitting Doctor

Admitting Doctors

Speciality

1a. Diagnosis / ICD Coding

1b. Cause and Pathology (if applicable) of the above diagnosis

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

 (dd) (mm) (yy)

2b. Was the patient previously treated for this condition?

 Yes No If yes, give details and when

 (dd) (mm) (yy)

2c. How long in your professional opinion has the condition existed?

 (dd) (mm) (yy)

3. Any possibility of a relapse?

 Yes No

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)

 Yes No If Yes, _____ months

7. If the hospitalisation was due to accident, please indicate date/time of accident:

 (dd) (mm) (yy) (hrs)

8. Discharge / Follow-up instructions

4a. Please ✓ Nature of Treatment and Investigation:

-
- Operation
-
- Physiotherapy
-
-
- Dietary Counselling
-
- Medications
-
-
- X-ray
-
- Blood Tests
-
-
- Others, give details _____
-
- _____
-
- _____

4b. If more than one procedure was involved, please state Type of Procedures performed:

| Type | Date | Name of Doctor |
|------|------|----------------|
| i. | | |
| ii. | | |
| iii. | | |

4c. Other medical conditions present?

Since (dd) (mm) (yy)Since (dd) (mm) (yy)Since (dd) (mm) (yy)

5. Was the condition

 congenital nervous mental

Signature and Name of Attending Doctor

Hospital Stamp

Date