ZURICH®

Personal Accident Claim Form

AGENCY NO. _____ **CLAIM NO.** _____

Notes:
The issue of this form is not an admission of liability by the Company. If the Claimant is unable to fill up this form personally it may be filled up on behalf of the Claimant. This form must be completed giving full particulars of any event in respect of which a claim is to be made and return to the Company at the office of the Company at which the Policy is issued as soon as possible, but in any case within fourteen days after the occurence of the accident.

1. Name of Claimant in Full _____

   NRIC No (New) _____ (Old) _____

   Address _____

   _____ Tel No: _____

   Name of Policyholder _____

   Date of Birth _____ Relationship (if different claimant) _____

   Policy No. _____ Period of Insurance From _____ To _____

2. Name of Employer _____

   Address _____

   _____ Tel No: _____

3. Date of Accident _____ Time _____ AM/PM

   Place of Accident _____

4. a) Please state in detail how the accident occured and what were you doing at the time.

   _____

   _____

   _____

   b) If accident involved other person(s) or motor vehicle(s), please state the name and address of the person(s) and/or the Registration Number of the vehicle.

   _____

   _____

5. Please state precisely the injuries that you have sustained.

   _____

   _____

6. Please give name and address of any persons who witnessed the accident.

   _____

   _____

7. a) Please give name and address of Medical Practitioner who attended to you after the accident.

b) Is he your usual Medical Attendant? If not, please state reason why he was consulted.

8. Please state whether you are entitled to compensation from any other source in respect of this accident. If so, please state the name of the company and the amount.

9. a) Have you ever met with any accident? If so, please give particulars.

b) Have you ever made a claim for compensation in respect of accidental injury from any Insurer? If so, please state the name of Insurer and the amount of compensation.

I hereby declare that I have complied in every respect with the terms and conditions of the policy and that I have not abstained from my usual occupation, either entirely or partially, longer than absolutely necessary in consequence of the said accident, and that such accident is the sole cause of my disablement.

I do hereby warrant the truth of the foregoing statements and particulars in every respect, and I agree that if I have made, or in any further declaration the officers of the Company may require of me in respect of the said claim shall make, any false or fraudulent statement or any concealment of material fact, the Policy shall be void as against the Company and my right to compensation absolutely forefeited, and I am willing, whenever required by the officers of the Company, to make a statutory declaration of the truth of all the foregoing statements, and of such other particulars as may be required by the officers of the Company.

Date

Signature of Policyholder/Claimant/
Employee & Company Stamp

Authorisation to Medical Practitioner, Hospital or Clinic

I hereby authorise any physician, practitioner, hospital or clinic by whom or where I have been examined or treated for any reason, to give full particulars thereof including prior medical history to **Zurich General Insurance Malaysia Berhad**. A photostat copy of this authorisation shall be deemed valid as the original.

I/We hereby give my/our unconditional and unequivocal consent to you and all your related companies to process my/our personal data revealed hereto. You are at liberty to process the data and share the information revealed thereto with any of your service providers and your other related companies provided that the revelation of my/our personal data strictly for the purposes in relation to the insurance which I/We have applied hereto. The consent given hereto is in line with the requirement set forth in the Personal Data Protection Act 2010.

Date

Signature of Policyholder/Claimant/Patient/Employee

N.B - Please have your medical attendant complete the Medical Certificate attached to this form

Zurich General Insurance Malaysia Berhad (1249516-V)
11th Floor, Menara Zurich, No.12, Jalan Dewan Bahasa, 50460 Kuala Lumpur, Malaysia
Tel: 03-2146 8000 Fax: 03-2144 1622 Call Centre: 1-300-888-622
www.zurich.com.my

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Medical Certificate Accident Claim

AGENCY NO. _____ **CLAIM NO.** _____

Notes:
The Company does not admit liability by the issue of this form. No Claim will be recognized unless this Medical Certificate is completed by a duly registered Medical Practitioner and forwarded to the Company as soon as possible.

This Medical Certificate must be obtained at the Insured's own expense.

1. Name of Patient _____

   NRIC No (New) _____ (Old) _____

   Date of Birth _____ Sex _____

   Business/Occupation _____

2. a) Date of Accident _____ Time _____ AM/PM

   b) Cause of Injuries _____

   _____

   c) Please state explicity of the injuries sustained by the patient:

   _____

   _____

   d) Please state details of treatment given to patient

   _____

   _____

   e) Is the patient hospitalized? If so, please state the duration _____

3. a) Are you the patient's regular medical attendant? If so, how long have you known the patient and for what ailments or injuries have you treated him?

   _____

   _____

   b) Are the injuries sustained consistent with the circumstances of the accident as described to you by the patient?

   _____

   c) Was the patient suffering from any disease or physical infirmity at the time of accident?

   _____

   d) Is there any previous medical history of disablement which may have contributed directly on indirectly to the accident or which may likely retard the patient's recovery?

   _____

e) Have you any reason to suspect that the patient was under the influence of intoxicants or drugs at the time of accident?

_____

_____

4. a) What is the present condition of the injuries? If recovered, please give date of recovery.

_____

_____

b) Please give dates of your visits to the patient and/or the patient's visit to you as from the date of accident.

_____

_____

5. Keeping in view of his/her occupation as a "_____", what do you feel the disability indicated below should be in:

(i) Temporary Total Disability (TTD), was from _____ until _____
(Day) (Month) (Year) (Day) (Month) (Year)

(ii) Temporary Partial Disability (TPD), was from _____ until _____
(Day) (Month) (Year) (Day) (Month) (Year)

I HEREBY CERTIFY HAVING EXAMINED THE ABOVE NAMED AND THAT MY FOREGOING STATEMENT ARE CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signature and stamp of
Attending Physician/Surgeon _____

Address _____

_____

_____

_____

Date _____ Qualification _____

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