TAKAFUL IKHLAS FAMILY BERHAD Registration No. 200201025412 (593075-U)
IKHLAS Point, Tower 11A, Avenue 5, Bangsar South,
No. 8, Jalan Kerinchi, 59200 Kuala Lumpur
Tel : 03-2723 9999 Fax : 03-2723 9998
IKHLAS Care : 03 2723 9696 Website: www.takaful-ikhlas.com.my

(Licensed under Islamic Financial Services Act 2013 and regulated by Bank Negara Malaysia)

BORANG TUNTUTAN - KELUARGA
CLAIM FORM - FAMILY

Peringatan / *Reminders*

Penerimaan borang ini bukanlah bermakna dengan sendirinya tanggungan akan diakui oleh syarikat.
Acceptance of this form does not mean admission of liability by the company.

NO. SIJIL / ***CERTIFICATE NO.*** **:**

Jenis-jenis tuntutan (sila tandakan √ di petak yang berkenaan)
Boleh tanda (√) lebih dari 1 petak

Type of claims (please tick √ in the related box provided)
You may tick (√) more than 1 box

- ☐ Tuntutan Kematian / *Death Claim*
- ☐ Tuntutan Keilatan Kekal Menyeluruh (TPD) / *Total & Permanent Disability Claim*
- ☐ Tuntutan Keilatan Kekal Separa (PD) / *Partial & Permanent Disability Claim*
- ☐ Tuntutan Elaun Hospital (HIB) / *Hospital Income Benefit*
- ☐ Tuntutan Penyakit Kritikal / *Critical Illness Benefit*
- ☐ Lain-lain, sila nyatakan / *Others, please state* ____________________
- ☐ Tuntutan Pengecualian Sumbangan / *Waiver of Contribution Claim*
- ☐ Tuntutan Manfaat Pendapatan Keluarga (Family Income) / *Family Income Benefit*
- ☐ Tuntutan Komprehensif Kemalangan Diri Berkumpulan (CPAB) / *Comprehensive Personal Accident Claim*
- ☐ Tuntutan Manfaat Ikhlas Wanita / Manfaat Cara Hidup / *Ikhlas Wanita Claim / Living Benefit*
- ☐ Tuntutan Ganjaran Tunai / *Cash Reward*

A. MAKLUMAT PESERTA / *PARTICIPANT'S DETAILS*

1 a. Nama Peserta / *Name of Participant* : ____________________

b. No. Kad Pengenalan/ *NRIC No. :* Baru/ *New :* __________ Lama/ *Old :* __________

2 Alamat / *Address* : ____________________

Poskod / *Postcode* : __________ Bandar / *Town* : __________

Negeri / *State* : __________

3 No. Telefon : / *Telephone No. :*
a. Telefon Bimbit / *H/p* : __________
b. Rumah / *House* : __________
c. Pejabat / *Office* : __________
d. Sambungan/ *Extention No.* : __________

4 E-Mel/ *E-Mail* : __________

5 Pekerjaan Semasa : / *Present Occupation :* __________ Nama Majikan & Alamat : / *Name of Employer & Address :* __________

6 Nama Bank/ *Name of Bank* : __________

7 No. Akaun Bank Peserta / Waris : / *Participant/ Beneficiary Bank Account No. :* Contoh: MBB0001. / *E.g: MBB0001.* __________

** Sila lampirkan salinan muka hadapan buku bank / *** Please enclose a copy of the front page of the saving book.*

B. MAKLUMAT ORANG YANG DILINDUNGI / PERSON COVERED'S *PERSONAL DETAILS*

1 Nama Orang yang dilindungi (jika berbeza dengan A) / *Name of Person covered (if differs from A)* :

____

2 No. Kad Pengenalan/ *NRIC No. :* Baru/ *New :* __________ Lama/ *Old :* __________

3 Alamat / *Address* : ____________________

Poskod / *Postcode* : __________ Bandar / *Town* : __________

Negeri / *State* : __________

4 E-Mel/ *E-Mail* : __________

C. BUTIR-BUTIR PENUNTUT (UNTUK TUNTUTAN KEMATIAN SAHAJA) *CLAIMANT'S DETAILS (FOR DEATH CLAIM ONLY)*

Sila lengkapkan jika lain daripada A dan B / *Please complete if differ from A and B*

1 Nama / *Name* : ______

2 No. Kad Pengenalan/ *NRIC No.* : Baru/ *New* : ______ Lama/ *Old* : ______

3 No. Telefon : / *Telephone No.* :
- a. Telefon Bimbit / *H/p* : ______
- b. Rumah / *House* : ______
- c. Pejabat / *Office* : ______
- d. Sambungan/ *Extention No.* : ______

4 Hubugan dengan simati / *Relationship with the deceased* :

☐ Wasi / *Executer* ☐ Hibah / *Hibah* ☐ Pemegang Serah Hak / *Assignee*

5 Alamat / *Address* : ______

Poskod / *Postcode* : ______ Bandar / *Town* : ______

Negeri / *State* : ______

6 E-Mel/ *E-Mail* : ______

7 Adakah simati pernah menunaikan hajj semasa hayat beliau: ☐ Ya / *Yes* ☐ Tidak / *No*

Has the deceased ever performed hajj during his lifetime:

8 Nama Bank/ *Name of Bank* : ______

9 No. Akaun Bank Penuntut : / *Claimant's Bank Account No.* : ______

** Sila lampirkan salinan muka hadapan buku bank / *** Please enclose a copy of the front page of the saving book*

D. MAKLUMAT KEJADIAN/ PARTICULARS OF EVENT.

(Sila isikan keterangan pada bahagian yang berkaitan sahaja) ***Please complete the information in the relevant section***

1 a) Sebab kejadian. / *Cause of event.* ☐ Kemalangan/ *Accident* ☐ Sakit / *Disease* ☐ Others / *Lain-lain*

Keterangan mengenai kejadian. / *Details of event.* ______

b) Nama Penyakit/ *Diagnosis* : ______

c) Nama Hospital/ *Hospital's Name* : ______

d) Tarikh kejadian/ *Date of event* : ______ HH/*DD* BB/*MM* TT/*YY*

e) Tarikh Masuk Wad : / *Date Of Admission* :
- i) ______ HH/*DD* BB/*MM* TT/*YY*
- ii) ______ HH/*DD* BB/*MM* TT/*YY*
- iii) ______ HH/*DD* BB/*MM* TT/*YY*

f) Tarikh Keluar Wad : / *Date Of Discharge* :
- i) ______ HH/*DD* BB/*MM* TT/*YY*
- ii) ______ HH/*DD* BB/*MM* TT/*YY*
- iii) ______ HH/*DD* BB/*MM* TT/*YY*

2 Sila nyatakan tarikh kali pertama/ *Please state the exact date (first date)* a) menerima rawatan/ *received treatment* : b) disahkan mendapat penyakit tersebut/ *diagnosed with the illness* :	______ HH/*DD* BB/*MM* TT/*YY* ______ HH/*DD* BB/*MM* TT/*YY*
3 Sila nyatakan punca asal mendapatkan rawatan atau rujukan dari doktor tersebut. *Please state the reason for seeking treatment or referral from the said doctoror.*	
4 Sudah berapa lamakah Peserta menghidapi kesakitan/ kecederaan ini? *How long have you been suffering from these illness/ injuries?*	
5 Jika diakibatkan oleh kemalangan, sila nyatakan seperti berikut: *If accidental case please state the following:* a) Tarikh kemalangan/ *Date of accident* : b) Bagaimana kemalangan berlaku : / *Details description of the accident* : *Sila lampirkan salinan laporan polis/ laporan bedah siasat (jika ada) ** Please enclose a copy of police report or post mortem report (if any)*	______ HH/*DD* BB/*MM* TT/*YY* Masa: / *Time:* ______ *am/pm*

6 Nama dan alamat doktor yang pernah merawat.
Name and address of the doctors that have been consulted.

Tarikh Rawatan/ Kemasukan Hospital (Date of treatmen / Hospital admission)	Penyakit (Diagnosis)	Nama Doktor (Doctor's Name)	Alamat Klinik / Hospital (Clinic or Hospital address)

7 Sila nyatakan ujian yang telah dilakukan oleh doktor :
Please state the nature of investigations performed by the doctor :
i.e. X-ray, ECG,blood test,etc

8 Sila nyatakan jenis rawatan atau prosedur yang telah diberikan :
Please state the nature of treatments or procedures given :

E. LAIN LAIN TAKAFUL ATAU PAMPASAN / *OTHER TAKAFUL OR COMPENSATION*

Adakah Peserta membuat tuntutan atau pampasan dari syarikat insuran atau takaful yang lain? ☐ YA / *YES* ☐ TIDAK / *NO*
Is the Participant claiming the benefits under any other insurance companies or takaful operators?

Jika YA, sila berikan maklumat lanjut / *If YES, please give details* :

F. PENGAKUAN OLEH PENUNTUT / *DECLARATION BY THE CLAIMANT*

Saya / Kami ___________________________ No. KP ___________________________ pihak yang membuat tuntutan mengakui bahawa semua jawapan dan kenyataan yang tercatat di atas adalah lengkap dan benar sepanjang pengetahuan dan keyakinan Saya / Kami dan Saya / Kami tidak menyembunyikan atau merahsiakan butir-butir penting dari syarikat ini. Saya / Kami dengan ini menuntut manfaat Takaful dan lain-lain perolehan di bawah Pelan Takaful yang berkenaan daripada Takaful Ikhlas Family Berhad (selepas ini dirujuk sebagai pihak Syarikat) dan bersetuju bahawa kenyataan dan maklumat dari semua doktor yang memberi rawatan kepada simati / peserta semasa hayatnya dan segala dokumen lain diberi untuk menyokong ini adalah menjadi bukti kematiannya / keilatannya. Selanjutnya, Saya / Kami bersetuju bahawa borang ini dan lain-lain dokumen tambahan yang diberikan mengenainya dan tindakan-tindakan siasatan dan pemeriksaan oleh pihak Syarikat tidak boleh ditaksir atau dianggap persetujuan menanggung tuntutan oleh pihak Syarikat dan tidak membuktikan ada sesuatu aqad Takaful yang berkuatkuasa mengenai diri yang diperkatakan atau sesuatu pelepasan sebarang hak atau pembelaan oleh pihak Syarikat. Saya / Kami dengan ini bersetuju membenarkan doktor-doktor atau lain-lain pihak atau hospital dan sebagainya memberi kepada pihak Syarikat penerangan atau maklumat yang mungkin diperlukan mengenai simati / peserta.

I / We ___________________________ NRIC ___________________________ as the claimant hereby declare that all foregoing answers and information stated above are complete and true to the best of my / our knowledge and belief and I / We have not concealed any important details from this company. I / We hereby claim Takaful benefits and other acquisition under the relevant Takaful Plan from Takaful Ikhlas Family Berhad (hereinafter referred as the Company) and agree that all information disclosed by the doctors treating the deceased / participant during his lifetime and all documents provided to support this claim is proof of his / her death / disability. Further, I / We agree that this form and other additional related documents and investigations or examinations by the Company cannot be interpreted or assumed as admission of liability by the Company and is not proof of any agreement which take effect on the said person or discharged of any right or defense by the Company. I / We hereby give consent to doctors or related parties or hospitals etc. to disclose to the Company any explaination or information which is deemed necessary with regards to the deceased / participant.

Tandatangan Penuntut / Peserta *Signature of Claimant / Participant*	Tandatangan Saksi *Signature of Witness*
Nama/ *Name* :	Nama/ *Name* :
No. KP/ *NRIC No.* :	No. KP/ *NRIC No.* :
Tarikh/ *Date* :	Tarikh/ *Date* :
Cop Syarikat/ *Company Stamp* : (For Group Master Certificate)	Hubungan/ *Relationship* :

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ATTENDING PHYSICIAN STATEMENT
(TOTAL / PARTIAL PERMANENT DISABILITY)

Reminders :
1 This form must be completed by the certified Medical Officer who had treated the patient.
2 Any cost incurred in relation to this report is to be borne by the patient.

CERTIFICATE NO. ______

A. PATIENT'S PERSONAL DETAILS

1 a. Name ______________________

b. NRIC No. New ______________ Old ______________

c. Age ______ d. Sex Male ☐ Female ☐

2 Occupation : ______________________

B. BACKGROUND

1 Please describe your patient's illness and disease symptoms	
2 a. Are you the claimant's usual medical attendant?	☐ Yes ☐ No
b. If yes, how long have you been his private medical attendant?	
c. What date does your record commence?	☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY
3 a. Date of first consultation for this disability.	☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY
b. Was the patient referred from clinic / hospital? If Yes, please state the clinic's / hospital's name.	
c. Date patient first absent from work.	☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY
d. Date of admission to hospital, if any.	☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY
e When was the last follow-up of the patient for the above illness, if any.	☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY
4 a. Has your patient suffered any previous episode of this disability?	☐ Yes ☐ No
b. If yes, please give details, dates and periods of absence from work	
5 a. Is this disability related to any other condition which your patient has suffered in the past?	☐ Yes ☐ No
b. If yes, please give details including 1st date of diagnose /	
6 Does the patient suffer any illness such as diabetes mellitus, hypertension, ischemic heart disease or etc?	Hypertension ☐ Yes ☐ No Date 1st diagnosed ______ Diabetes Mellitus ☐ Yes ☐ No Date 1st diagnosed ______ Others ☐ Yes ☐ No Name of illness: ______ Date 1st diagnosed ______
7 a. Do you have reason to suspect that this illness / injury is included by the influence of alcohol or drugs, pregnancy or child birth, deliberate action, HIV infection, AIDS or mental or nervous disorder?	☐ Yes ☐ No
b. Does the participant's condition related to attempted suicide or willful self injury	☐ Yes ☐ No Details: ______ ______ ______

C. PATIENT'S PRESENT CONDITION

1 Please state a precise diagnosis of his / her present illness	
2 a. Is the patient suffering from any other conditions?	☐ Yes ☐ No
b. If yes, does it affect the condition described above?	

3 Ever since the diagnosis of his / her condition, has your patient; a. recovered? If yes, please give date b. improved? If yes, please give date c. experience no changes d. deteriorate	 ☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY ☐☐ / ☐☐ / ☐☐☐☐ DD MM YYYY ☐ Yes ☐ No ☐ Yes ☐ No
4 What particular aspect of the patient's present condition prevent him / her from returning to work?	
5 If the disability relates to mental illness, what is the patient's current mental state? Please give details.	
7 What is the patient's Mini Mental State Examination (MMSE) result? Kindly attach the report.	
6 What is the patient's pain score?	a) At rest : ____________________ b) On movement : ____________________
8 Are these any other circumstances, medical or otherwise, which may delay your patient's recovery?	

D. TREATMENT

1 Please give full details on all medicines that have been prescribed to your patient (including dosages).	
2 Please give full details of any surgical procedures performed in connection with his / her condition.	
3 Please provide details of any other treatment being prescribed including physiotherapy.	
4 Did you recommend your patient to undergo further investigation or surgical procedures?	
5 Has your patient been treated as in-patient in a hospital or other medical centres for this condition? If yes, give full details.	☐ Yes ☐ No
6 Has your patient been an outpatient by any consultant, specialist or other member of the medical profession in connection with this condition? If yes, please give full details including the date of consultant, name of hospital and doctor's name	☐ Yes ☐ No

Consultation Date	Diagnosis	Name of doctor and address

7 Have you taken any blood pressure readings during the period of disability? If yes, please give details and dates of the readings.	☐ Yes ☐ No
8 Is your patient's height and weight within normal bounds?	☐ Yes ☐ No
9 Has there been any recent fluctuation of weight? If yes, please give full details.	☐ Yes ☐ No
10 Please give details of any investigations, tests or procedures that have been undertaken in connection with this condition, including the results.	

E. DEGREE OF DISABILITY

1 a. Is your patient	☐ Ambulatory ☐ Confined to his / her home ☐ Confined to bed ☐ Subject to some restriction in movement of lifestyles
b. Please give details	
2 Please tick (√) the box on the activities that the participant are unable to perform : ☐ Transfer or Mobility - the ability to move from one room to an adjoining room or from one side of a room to another or to get in and out of a bed or chair without requiring the physical assistance of another person; ☐ Continence - the ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene; ☐ Dressing - putting on and taking off all necessary items of clothing without requiring any assistance of another person; ☐ Toileting - the ability to wash in the bath or shower, transferring on or off the toilet and associated personal ☐ Eating - all tasks of getting food into the body once it has been prepared	b. Please describe in detail.

3 What do you consider that your patient is capable of?	☐ Following his / her normal occupation on a full time basis ☐ Following his / her normal occupation on a part time basis ☐ Following a different occupation ☐ Cannot perform any occupation
4 What aspect of the patient's illness renders the patient unable to perform **any occupation**? Please give details.	
5 What do you consider your patient's disability to be?	☐ Total permanent ☐ Partial permanent
6 If you consider that the patient is under Partial Permanent Disability (PPD), please describe the part of the body which was under PPD. (Please draw the picture for further explanation)	
7 Please state the percentage of permanent disability of the patient (from 100% use of body), and the date commenced.	Percentage : ____________________ Date of commence disability: ____________
8 Does he have any cognitive impairment? If Yes, please give details.	
9 What is power of both the upper and the lower limbs during his last visit	(see table below)
10 Is the participant suffered any loss of vision? If Yes, during his visitation, what is his current visual acuity	(see table below) Please give details: ____________________ ____________________ ____________________ ____________________
11 When do you think the patient will be able to resume working either to his present job or alternative employment?	

Parts of limb	**Muscle Power**
Right upper limb	
Right lower limb	
Left upper limb	
Left lower limb	

Right Eye	Left Eye

F. FURTHER / ADDITIONAL INFORMATION

1 Please state any information which you feel would be helpful in the assessment of your patient's claim.	
2 Do you have any diagnosis or reports from hospitals or consultants that would help our consultant medical officer to consider this claim? If yes, please provide copies or extract of such reports if you would prefer	

G. CLAIMANT'S PROGNOSIS

1 What aspect of your patient's disability will prevent him / her from undertaking in any work in the future?	
2 If you feel that the patient could follow a different occupation, can you please give an indication as to the type of work that he / she could undertake.	
3 When do you think the patient will be able to resume working either to his present job or alternative employment?	

H. FURTHER / ADDITIONAL INFORMATION

1 Please state any information which you feel would be helpful in the assessment of your patient's claim.	
2 Do you have any diagnosis or reports from hospitals or consultants that would help our consultant medical officer to consider this claim? If yes, please provide copies or extract of such reports if you would prefer	

I. DECLARATION

I hereby declare to the best of my knowledge and belief the foregoing particulars in the reports are true and correct in every aspect.

-- Signature of Medical Officer

-- Hospital Official Stamp

Name of doctor : --

Qualification : --

Date : --

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BORANG PELEPASAN TUNTUTAN
CLAIM RELEASE FORM

1. Nama Peserta (Huruf Besar) *Name of Participant (Capital Letter)*	
2. Nombor Sijil *Certificate's Number*	
3. Jenis Pelan *Plan Type*	
4. Nombor Rujukan Tuntutan *Claim Reference Number*	
5. Jumlah Ditawarkan / Dijelaskan *Amounts Offered / Settled*	RM

PENGAKUAN / *DECLARATION*

Saya/Kami sebagai pemegang sijil bernombor seperti di atas yang dikeluarkan oleh Takaful Ikhlas Family Berhad dengan ini mengemukakan tuntutan saya/kami terhadap Faedah Takaful/Akaun Pelaburan Peserta/Faedah Tambahan saya/kami menurut terma dan syarat yang terkandung di dalam sijil.

Saya/Kami dengan ini bersetuju menerima jumlah yang ditawarkan dan dengan demikian Takaful Ikhlas Family Berhad tidak lagi bertanggungjawab ke atas sijil berkenaan yang dianggap tidak sah dan terbatal dan berhak untuk tidak melayan sebarang tuntutan daripada saya/kami atau lain-lain pihak yang mewakili saya/kami.

I/We as the rightful holder/s of the certificate bearing the above number as issued by Takaful Ikhlas Family Berhad hereby submit my/our claim for Takaful Benefits/Participant Investment Account/Supplementary Benefits in accordance with the terms and conditions in the said certificate.

I/We hereby agree that with the amounts offered and accepted by me/us, Takaful Ikhlas Family Berhad will no longer be held liable on the certificate which has been rendered null and void and entitled not to entertain any claim from me/us or any party acting our my/our behalf.

____________________	____________________
Tandatangan Peserta/Penuntut *Signature of Participant/Claimant*	Tandatangan Saksi *Signature of Witness*
Tarikh : *Date* : __________	Tarikh : *Date* : __________
Nama : *Name* : __________	Nama : *Name* : __________
Alamat : *Address* : __________	Alamat : *Address* : __________

Cop Syarikat :
Company Stamp:
(For Group Master Certificate)