

# MEDICAL REPORT – HOSPITALISATION CLAIM

## Outline / Overview :

### 1. Policy & Patient Information

- Policy number, patient's name, I/C number, age, and gender.

### 2. Hospital Admission Details

- Admission number, date/time of admission & discharge.

### 3. Accident Details

- Date/time of accident and nature of accident.

### 4. Consultation & Referral

- First consultation date, referral details if applicable.

### 5. Symptoms & Diagnosis

- Symptoms, duration, past treatments, tests, and diagnosis details.

### 6. Treatment & Surgery

- Medical treatment given, surgery details (operation, surgeon, date, anaesthesiologist).

### 7. Prognosis & Medical History

- Possibility of relapse, past hospitalisations, previous treatments.

### 8. For Female Patients Only

- Pregnancy status, illness related to pregnancy or childbirth.

### 9. Declaration & Signature

- Doctor's name, signature, and date of declaration.

## Detailed View:

### 1. Policy & Patient Information [from point 1 to 4]

1. **Policy Number:** [Text field]
2. **Patient's Full Name:** [Text field]
3. **Identification Number (I/C No.):** [Text field]
4. **Age / Gender:** [Number field for age] [ Male / Female / Other]

### 2. Hospital Admission Details [from point 5 to 7]

5. **Admission Number:** [Text field]
6. **Date & Time of Admission:** [Datetime]
7. **Date & Time of Discharge:** [Datetime ]

### 3. Accident Details (If Applicable)[from point 8 to 10]

**8. If hospitalisation was due to an accident, please provide:**

- (a) **Date & Time of Accident:** [Datetime ]
- (b) **Nature of the Accident:** [Textarea for details]

**4. Consultation & Referral Information [point 9 and 10]**

9. **Date of First Consultation for This Illness/Injury/Condition:** [Date ]

10. **Was the patient referred to your hospital by another doctor?** [Radio button: Yes / No]

- If **Yes**, please provide:

- **Referring Doctor's Name:** [Text field]
- **Referring Doctor's Address:** [Textarea]

**5. Symptoms & Diagnosis[from point 11 to 16 ]**

11. **Symptoms reported during the initial consultation:** [Textarea for details]

12. **Duration of Symptoms:**

- (a) **As reported by the patient:** [Text field – days/weeks/months]
- (b) **Medical assessment:** [Text field – estimated duration in days/weeks/months]

13. **Previous Treatments:** [Checkbox: Yes / No]

- If **Yes**, please provide:

- **Name & Address of Treating Doctor(s):** [Textarea]
- **Date(s) of Consultation:** [Date ]

14. **Have any investigation, test, or procedure been performed?** [Checkbox: Yes / No]

- If **Yes**, please attach a certified true copy of the result.

15. **What was your diagnosis?** [Textarea for details]

16. **Did you inform the patient of the diagnosis?** [Checkbox: Yes / No]

- If **Yes**, when? [Date ]

**6. Treatment & Surgery Details [point 17 and 18]**

17. **Nature of medical treatment given:** [Textarea]

18. **For Surgery:**

- (a) **Nature of Operation Performed:** [Text field]
- (b) **Nature of Surgeon:** [Text field]
- (c) **Date of Surgery:** [Date]
- (d) **Name of Anaesthesiologist:** [Text field]

## 7. Prognosis & Medical History [point 19 to 20]

19. Any possibility of the patient having a relapse? [Checkbox: Yes / No]
20. Has the patient previously been treated or hospitalised in this or any other hospital for this or any other disease?
- [Checkbox: Yes / No]
  - If Yes, please provide details:
    - Date of Injury/Illness: [Date]
    - Name & Address of Clinic / Hospital: [Textarea]

## 8. Additional Information for Female Patients [point 21]

21. For Female Patients Only:
- (a) Was the patient pregnant at the time of hospitalisation? [Checkbox: Yes / No]
    - If Yes, for how many months? [Number field]
  - (b) Was the illness caused directly or indirectly by pregnancy, childbirth, caesarean section, abortion, miscarriage, or any related complications? [Checkbox: Yes / No]

## 9. Declaration & Signature

I hereby declare that the above answers are true to the best of my knowledge.

Doctor's Name & Signature: \_\_\_\_\_

## Hospitalisation & Surgical Claim - Claimants

### Policy Details

1. Policy No.: [Text Field]
2. Claim Amount: [Number Field]

### Payment Details

3. All eligible claim payments will be credited to the bank account stated in the E-Payment (Direct Credit) Authorisation Form.
4. Payment will be processed within 5 working days from claim approval.

5. If there is any change in bank account details, a new E-Payment form must be submitted.

### **Cause of Claim**

6. Sickness: [Checkbox]  
7. Accident: [Checkbox]

### **Document Checklist**

8. Claimant Statement: [Checkbox]  
9. Medical Report: [Checkbox]  
10. Claimant's NRIC (Certified Copy): [Checkbox]  
11. Original Tax Invoice(s) / Final Bill(s) & Itemized/Detailed Bill(s): [Checkbox]  
12. Original Official Receipt(s): [Checkbox]  
13. Diagnostic Report / Test Result (if any): [Checkbox]  
14. Copy of Referral Letter (if any): [Checkbox]  
15. E-Payment Authorisation Form: [Checkbox]

### **Particulars of Life Assured**

16. Name: [Text Field]  
17. NRIC No.: [Text Field]  
18. Old IC No.: [Text Field]  
19. Passport No. (For Foreigners): [Text Field]  
20. Email: [Email Field]

### **Details of Employment**

21. Name of Employer: [Text Field]  
22. Tel. No. (Office): [Text Field]  
23. Address of Employer: [Text Field]  
24. Postcode: [Text Field]

### **Particulars of Claimant / Policy Owner**

25. Name: [Text Field]  
26. NRIC No.: [Text Field]  
27. Old IC No.: [Text Field]  
28. Passport No. (For Foreigners): [Text Field]

### **SMS Notification**

29. Claimant's Mobile No.: [Text Field]

## **Hospitalisation Details (Illness)**

- 30. Admission Date: [Date Field]
- 31. Discharge Date: [Date Field]
- 32. Name of Hospital / Medical Center: [Text Field]

## **Hospitalisation Details (Accident)**

- 33. Date of Accident: [Date Field]
- 34. Time of Accident: [Time Field]
- 35. Place of Accident: [Text Field]
- 36. How the Accident Occurred: [Text Field]
- 37. Nature and Extent of Injury: [Text Field]

## **Consultation Details**

- 38. Doctor First Consulted for this Illness / Injury: [Text Field]
- 39. Doctor Who Referred to Hospital: [Text Field]
- 40. All Other Doctors Consulted: [Text Field]
- 41. Usual Medical Attendant / Family Doctor: [Text Field]

## **General Information**

- 42. Is the patient insured with other companies? [Checkbox]
- 43. If Yes, Provide Company Name & Policy Details: [Text Field]

## **Signatures**

- ★ Signature of Life Assured,
- ★ Signature of Claimant/ Policy Owner and
- ★ Signature of Witness

## **Processing of the Personal Data**

Allianz Life Insurance Malaysia Berhad collects and processes your personal data to handle claims under the Personal Data Protection Act 2010

Data Sources: Information may come from you, family members, regulatory agencies, insurance intermediaries, medical professionals, employers, and other relevant parties.

**Failure to Provide Data:** Supplying personal data is mandatory for claim processing. Without it, claims may be denied.

### **Purpose of Use:**

- Processing, evaluating, and settling claims
- Fraud prevention and compliance
- Updating records and statistical analysis
- Sharing with affiliates or authorized third parties, including international entities

Disclosure Data may be shared with insurers, brokers, auditors, regulators, medical professionals, and service providers as required by law.

## **E-Payment (Direct Credit) Authorization Summary**

### **Authorization & Agreement**

The policyholder authorizes Allianz Life Insurance Malaysia Berhad (ALIM) to directly credit any due payments from their policies into their bank account as per the policy currency. This request is governed by ALIM's Terms & Conditions.

### **Required Information**

1. **Policyholder Details:**

Name, NRIC/Passport No., Mobile No., Email Address

2. **Bank Account Information:**

- **For MYR Accounts:** Bank Name, Account No., Account Type (Individual/Joint)
- **For Foreign Currency Accounts:** Currency, Bank Name, Account No., Swift Code, Bank Code, Bank Country

### **Important Notes**

1. Direct credit applies only to the policy owner's bank account.
2. A copy of NRIC/Passport and bank statement/passbook is required for verification.
3. Direct credit is available only for banks under the Interbank Giro Payment System (IBG).
4. Payments **cannot** be credited to:
  - Overseas accounts
  - Corporate accounts (for keyman/mortgage reducing term assurance policies)
  - Accounts not in the policy owner's name
  - Joint accounts (unless the policy owner is the primary holder)

### **Terms & Conditions**

1. Payment to the specified account discharges ALIM's liability.
2. ALIM is not liable for incorrect transactions due to errors in the provided details.
3. Any overpayment must be refunded to ALIM.
4. The policyholder indemnifies ALIM against any claims related to the payment.
5. ALIM may issue payment by cheque if documentation is incomplete or inconsistent.
6. Information provided may be shared with relevant parties for processing and legal compliance.
7. ALIM may update the policyholder's contact details based on this form.

## **Signatures**

- **Policy Owner/Assignee & Witness** must sign and date the form for authorization