HealthMetrics

LETTER OF CONSENT/ AUTHORISATION

PATIENT ADMISSION DETAILS	
PATIENT NAME	COMPANY NAME
PATIENT ID (IC/ PASSPORT)	HOSPITAL NAME
MRN/ ADMISSION NUMBER	ADMISSION DATE
DATE OF BIRTH/ AGE	PRINCIPAL'S NAME AND ID (IC/ PASSPORT)

PATIENT'S DECLARATION AND AUTHORISATION

I declare that the answers given to the admitting doctor are true and complete to the best of my knowledge and belief.

I understand the delivery of this form is in no way to admission of claim by HealthMetrics/ Payor Company and payment to the hospital by HealthMetrics/ Payor Company or its presentative shall not construed as final admission of claim by HealthMetrics/ Payor Company for this and any further claims arising, HealthMetrics/ Payor Company reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my/ covered person's medical entitlement under the above-mentioned policy. I hereby undertake to settle/ reimburse any medical expenses exceeding my entitlement under the said policy contact, or that is not covered by the same.

I hereby irrevocably authorise any organisation, institution, or individual that has any record of knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident/ injury, to disclose to HealthMetrics/ Payor Company or its representation such information. I agree that HealthMetrics/ Payor Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including HealthMetrics's/ Payor Company's parent company, subsidiaries or any other associated companies within the HealthMetrics/ Payor Company Group, reinsurers, medical examiners, claims investigators and industry associations/ federations etc.) in relation to this claim. This authorisation shall bind my/ the covered person's successors and assigns and remain valid notwithstanding my/ covered person's incapacity in so far as legally possible. A photocopy or electronic copy of this authorisation shall be valid as the original.

I agree that in the event I make, or have in the past made, any false or untrue statement and/ or suppressed and/ or concealed any material facts in respect of my/ the covered person's condition. HealthMetrics/ Payor Company shall absolutely forfeit my/ the covered person's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

Signature of patient:	Signature of principal/ claimant:	Signature of witness:
Full name:	Full name:	Full name:
Patient ID (IC/Passport):	Patient ID (IC/Passport):	Patient ID (IC/Passport):
Date:	Date:	Date:
	Contact number:	Contact number:
	Relationship to patient:	