



# MUI Continental Insurance Berhad (29123-D)

Head Office / KL Branch

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## Customer Service Department

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A member of The MUI Group  
In Association with CNA Insurance, USA

## STATEMENT OF CLAIM

Hospitalisation and Surgical Insurance

### INSTRUCTIONS

1. This form must be fully completed to avoid any delay in the settlement of claim.
2. Itemised original bills and receipts covering hospitalization and surgical expenses for which claim is made must be attached.
3. If the patient is a child, the insured employee should sign the statement of consent.

### TO BE COMPLETED BY THE EMPLOYEE AND EMPLOYER

1. Name of Employer/Insured	Policy No:	Occupation	Date of Birth:
	Hospital O/Patient Card No.	Employee	Date Eligible for Insurance
2. I/C No:	Race	Plan/Coverage:	Date of Employment:

### TO BE COMPLETED IF CLAIM MADE FOR INSURED DEPENDENT

1. <input type="checkbox"/> Spouse	Name:	Date of Marriage:
<input type="checkbox"/> Son/Daughter	Name:	Date of Birth:
2. Is the dependent employed? <input type="checkbox"/> No <input type="checkbox"/> Yes, by whom?	Occupation	

### ACCIDENT (PLEASE OMIT IF NOT APPLICABLE)

1. Date	2. Time	3. Place	4. At Work <input type="checkbox"/> Yes <input type="checkbox"/> No
5. State how it happened.			

### SICKNESS (PLEASE OMIT IF NOT APPLICABLE)

1. Nature of illness	2. Date First Diagnosed	3. Date First Treated:
4. Has this condition been treated previously? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "yes", Name of Doctor.....		
Address .....		

### OTHER INFORMATION

1. Name of Hospital/Clinic	2. Address	
3. Date Admitted/Treated	4. Date Discharged, if hospitalised	5. Date Surgery Performed
6. Has claim been filed for Workmen's Compensation/Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Will such claim be filed <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Claim cheques should be made payable to: <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Employer/Insured <input type="checkbox"/> Employee		
9. Sick leave: From ..... To ..... No. of days: .....		

Date: .....

.....  
Signature of Employer/  
Company's Chop

### STATEMENT OF CONSENT

I hereby authorize any physician, or any hospital who has attended me to furnish or disclose all known facts concerning this disability to MUI Continental Insurance Berhad. A photostat copy this authorisation shall be considered as effective and valid as the original.

Date: .....

.....  
Signature of Patient/Employee

# MEDICAL REPORT

NOTICE FOR HOSPITAL - To expedite settlement of the Claim, please answer all questions herein and attach all your original bills and/ or receipts covering all hospital charges incurred during the confinement.

**Part 2**

<p>1. Name of Patient _____ Sex _____</p> <p style="text-align: right;">Age _____</p>	<p>2. Hospitalization was recommended by _____</p>
<p>2. Hospital _____</p>	<p>4. Date of confinement:</p> <p>Admitted on _____, 19 _____ at _____ M</p> <p>Discharges on _____, 19 _____ at _____ M</p>
<p>5. a. (i) Nature of sickness or injury (complete diagnosis) _____</p> <p>(ii) Underlying Disease _____ Duration _____ Yrs _____ Months _____ Days _____</p> <p>(iii) Cause and Pathology of Diagnosis _____</p> <p>b. Is the disability arising from patients employment? _____</p> <p>c. Is disability due to pregnancy/childbirth? _____</p> <p>d. If "yes" what was the approximate date of commencement of pregnancy? _____</p> <p>e. Is disability due to infertility? _____</p> <p>f. Is disease congenital? _____</p> <p>g. Is condition hereditary? _____</p> <p>h. Is condition related to nervous or mental disorder? _____</p> <p style="margin-left: 20px;">If yes, please specify:</p> <p>i. is condition treated for cosmetic reason? _____</p> <p>j. Is condition related to alcohol abuse? _____</p>	
<p>6. a. Short history of illness or disability? _____</p> <p>b. Date you were first consulted _____</p> <p>c. Has patient ever had same or similar condition _____</p> <p>d. If "yes" please state when _____</p> <p>e. How long has this injury or sickness been existing prior to consulting you? _____</p> <p>f. Names and address of Doctors previously consulted by patient for the illness _____</p> <p>g. Final Diagnosis _____ Duration _____ Yrs _____ Months _____ Days _____</p>	
<p>7. Complete if surgery was performed</p> <p>a. Nature of operation/obstetrical procedure performed _____</p> <p style="margin-left: 20px;">Please check where applicable: Is operation <input type="checkbox"/> Major <input type="checkbox"/> Med <input type="checkbox"/> Minor</p> <p>b. Date performed _____</p> <p>c. Treatment provided _____</p> <p>d. Name of Surgeon _____</p>	
<p>8. In case of accident please state:</p> <p>a. Type of fracture: _____</p> <p>b. Nature of treatment: _____</p>	
<p>9. Remarks, if any _____</p>	

I hereby certify that the answer above are full, complete and true.

.....  
Name and address of Physician

Date : .....

.....  
Signature