Asia Specialty Insurance Limited
Formerly known as Asia Insurance Limited (Company No: LL08800)
8th Floor, Wisma Genting, Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia.
Tel: +603 2162 1128 Fax: +603 2164 1128
Email: general@asil.my Website: www.asil.my

Golden Protection Personal Accident Claim Form

Kindly submit following documents together with supporting documents according to the benefit you are claiming for:

1. Completed Claim Form
2. Certified NRIC/Passport (Life Assured & Claimant)

Type of Claim:

☐ **Personal Accident (Accidental Death)**	☐ **Personal Accident (Total Permanent Disablement)**
☐ Police Report / Accident Report (Original) ☐ Certified Death Certificate ☐ Certified Post Mortem ☐ Letter from Embassy in country of destination (original)	☐ Police Report / Accident Report (Original) ☐ Medical Report (Original) ☐ Full length photograph (Life Assured)
☐ **Repatriation Expenses due to accident**	
☐ Receipt from Ambulance (original) ☐ Receipt for cost of all necessary arrangement (original)	

Policy	Policy No: _____ Date of insurance purchased: _____
Insured Person	Name: _____ Age: _____ Address: _____ Postcode: _____ _____ _____ Occupation: _____ NRIC / Passport No: _____ E-mail address: _____ Tel No: _____

Accident / Incident / Loss	Date & Time of accident: _____ Place of accident / Country: _____ Please describe how accident occurred: _____ _____ _____ _____ _____ Name and address of any witness: _____ _____ _____ _____ Nature and extent of injuries: _____ _____ _____ _____ _____ _____ Place of police report made: _____ Police Report No:_____

Please tick □ in the box the type of benefits you are claiming:-	**Amount Claimed (RM)**
□ **Personal Accident Benefit**	
□ Accidental Death – 100%	
□ Loss of two (2) limbs - 100%	
□ Loss of both hands, or of all fingers and both thumbs - 100%	
□ Total and irrecoverable loss of both eyes (whole eye and sight) – 100%	
□ Loss of One hand and one foot - 100%	
□ Loss of One foot and sight of one eye - 100%	
□ Total paralysis – 100%	
□ Injuries resulting in being permanently bed ridden - 100%	

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☐ Any other injury causing permanent total disablement - 100% ☐ Total and irrecoverable loss of eye (whole eye and sight) – 50% ☐ Loss of arm at shoulder – 50% ☐ Loss of arm between shoulder and elbow – 50% ☐ Loss of arm at elbow – 50% ☐ Loss of arm between elbow and wrist – 50% ☐ Loss of hand at wrist – 50% ☐ Loss of leg (at hip, between knee and hip and below knee) – 50% ☐ Loss of hearing both ears – 40% ☐ Loss of four (4) fingers and thumb of one (1) hand – 30% ☐ Loss of speech – 25% ☐ Loss of four (4) fingers - 20% ☐ Funeral Expenses cause by accident ☐ Repatriation Expenses due to accident (cost of all necessary arrangement including but not limited to transportation of mortal remains, undertaker, casket, embalming and/or cremation) up to USD2,000	

I/We hereby warrant that the above statements are true and correct and that I/We have not withheld from the Company any material information in connection with this claim. I/We further authorize the release of further medical information by the doctor should the Company require it. Any photo copied of this authorization shall be as effective and valid as the original.

Date: _____ Signature of Insured Person or Legal representative _____

Name _____

NRIC / Passport No _____

Relationship with Insured Person, if signed by Legal Representative _____

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MEDICAL CERTICATE/REPORT

Policy No :_____
Claim :_____

Name of Patient :	
NRIC / Passport No :	
Patient's Ref No :	Date of Accident :
Age : Sex (Male /Female) :	Time of Accident :
Occupation :	Date of Consulted :
1. a. Describe in detail how did the accident happen as related to you by the patient ? b. Describe in detail what injuries did the patient sustain? Is the condition due to pregnancy ? If yes, state date pregnancy commenced.	a. b. ☐ Yes ☐ No
2. a. Were there any external and visible injures seen as a result of this accident ? b. If yes, describe the extent of the injuries including site and other characteristic features as seen by you. c. Are the injuries consistent with the circumstances of the accident? If no, are the symptoms traceable to disease, infirmity or any other cause? Please give details.	a. ☐ Yes ☐ No b. c. ☐ Yes ☐ No
3. Is there anything in his/her medical history which may have contributed directly or indirectly to the accident or which may likely to retard his/her recovery? If yes, please give details	☐ Yes ☐ No

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4. How long has the patient been disable from engaging in or attending to this usual employment or occupation as a result of these injuries or illness?	☐ Totally Disablement From _____ To _____ ☐ Partial Disablement From _____ To _____
5. Do you feel that the injuries would have prevented him/her from working from the date of accident? If yes, and absence from work of more than 2 weeks was necessary, please describe in detail the reasons why you feel that the patient could not return to work earlier keeping in mind the occupation of the patient	☐ Yes ☐ No
6. Have you any reason to suspect the patient was under the influence of intoxicants at the time of accident?	

I hereby certify that I have personally examined and treated the patient for his/her injuries described above and that the facts as stated above represent my medical opinion of his/her condition

Signature of Attending Physician : _____

Name & Address :
(Official Stamp) _____

_____

_____

Qualification : _____

Date : _____

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