LONPAC INSURANCE BHD (307414-T)

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Internet Form
(Borang Internet)

SECTION ONE - HOSPITAL & SURGICAL INSURANCE CLAIMS FORM
SEKSYEN SATU - BORANG TUNTUTAN INSURAN HOSPITAL & PEMBEDAHAN

Our Claim No : _____
No. Tuntutan Kami

SECTION 1 – To be completed by the Insured / Claimant (IN BLOCK LETTERS)
SEKSYEN 1 – Untuk diisi oleh Pihak Diinsuranskan / Pihak Menuntut (DALAM HURUF BESAR)

Name of Insured *Nama Pihak Diinsuranskan*	NRIC No./Passport No. *No. K/P/ Pasport No.*	Policy No. *No. Polisi*

Claimant (other than the Insured) *Pihak Menuntut (selain daripada Pihak Diinsuranskan)*	Claimant is: *Pihak Menuntut ialah:* ☐ Self / *Diri Sendiri* ☐ Spouse / *Pasangan* ☐ Child / *Anak*	NRIC No./Passport No. (if applicable) *No. K/P/Pasport No. (jika diterima pakai)*

Birth Date *Tarikh Lahir*	Age *Umur*	Sex *Jantina*	Race *Bangsa*	Nationality *Warganegara*
☐ (dd) *Tarikh* ☐ (mm) *Bulan* ☐ (yy) *Tahun*	☐	☐ Male / *Lelaki* ☐ Female / *Perempuan*		

Religion *Agama*	Marital Status *Status Perkahwinan*	Occupation *Pekerjaan*	Nature of business (If self employed) *Jenis Perniagaan (Jika berniaga sendiri)*

Employer *Majikan* Tel. No./ *No. Tel:*	Employer's Address *Alamat Majikan*

Type of Claim
Jenis Tuntutan

☐ Hospitalisation / *Dimasukkan ke hospital*
☐ Outpatient / *Pesakit Luar*
☐ Accident / *Kemalangan*
Circumstances of Accident / Keadaan Kemalangan

If Claim payable, make cheques to
☐ Employer
☐ Employee

Details of other insurance policies, Socso, Workmen's Compensation and others:-
Butir-Butir insurance lain, Perkeso, Insurans Pampasan Pekerja dan lain-lain:-

Policy Type / *Jenis Polisi*	Insurance Company / *Syarikat Insuran*	Policy No. / *No. Polisi*

AUTHORISATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION
MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL ATAU KLINIK UNTUK MEMBERI MAKLUMAT

I hereby authorise any physician, medical practitioner, hospital or clinic by whom or where I have/my ward has been observed or treated, to give full particulars about my/ward's health including my/ward's whole medical history in respect of this hospitalisation/surgery, to the above insurance company.
Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital atau klinik yang merawat saya/tanggungan saya untuk memberi maklumat-maklumat lengkap berhubung dengan riwayat kesihatan saya/tanggungan saya termasuk latarbelakang penuh perubatan saya/tanggungan saya semasa dimasukkan di hospital/menjalani pembedahan kepada syarikat insuran.

.....	.....	.....
Signature of Patient *Tandatangan Pesakit*	Signature of Insured/Claimant Address/*Alamat:*	Date *Tarikh*

Tel No./*No. Tel:*
Tandatangan Pihak Diinsuranskan/Pihak Menuntut
(Company chop where applicable/Cop syarikat dimana perlu)

SECTION TWO - MEDICAL REPORT

SECTION II – To be completed by the Attending Doctor (IN BLOCK LETTERS) **MRN No:**

Name of Hospital and Address

Name of Patient | NRIC No.

Date and Time of Admission

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Date and Time of Discharge

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

Name of Referring Doctor and Address

Admitting Doctor | Attending Doctors | Speciality

1a. Diagnosis/ICD Coding

1b. Cause and Pathology (if applicable) of the above diagnosis

4a. Please √ Nature of Treatment and Investigation:

☐ OPERATION ☐ PHYSIOTHERAPY
☐ DIETARY COUNSELLING ☐ MEDICATIONS
☐ X-RAY ☐ BLOOD TESTS
☐ OTHERS, give details .....
.....
.....

4b. If more than one procedure was involved, please state Type of Procedures performed:

	TYPE	DATE	NAME OF DOCTOR
i.			
ii.			
iii.			

2a. When did patient first consult you for this condition?

☐ (dd) ☐ (mm) ☐ (yy)

2b. Was the patient previously treated for this condition?

☐ No ☐ Yes, give details and when

☐ (dd) ☐ (mm) ☐ (yy)

.....
.....
.....

2c. How long in your professional opinion has the condition existed?

☐ (dd) ☐ (mm) ☐ (yy)

4c. Other medical conditions present?

.....
Since (dd mm yy) .....
.....
Since (dd mm yy) .....
.....
Since (dd mm yy) .....

3. Any possibility of a relapse?

☐ Yes ☐ No

5. Was the condition

☐ congenital ☐ nervous ☐ mental

6. Was the patient pregnant at the time of hospitalisation? (For Females Only)

☐ No ☐ Yes, ... months

7. If the hospitalisation was due to accident, please indiciate date/time of accident:

☐ (dd) ☐ (mm) ☐ (yy) ☐ (hrs)

8. Discharge/Follow-up instructions

....

Signature and Name of Attending Doctor | Hospital Stamp | Date