MCIS INSURANCE BERHAD (435318-U)

Head Office:
Wisma MCIS, Jalan Barat,
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Medical Claim Form

(This form is ONLY applicable for Merchantrade Policies)

This form is to be completed by claimant. All questions must be answered. Dash (–) is not acceptable. Thank you.

A. SUPPORTING DOCUMENTS REQUIRED

1. Original payment receipts including deposit receipts and itemized medical bills
2. Admission and Discharge Card / Discharge Note
3. Laboratory and Radiology Reports

B. TYPES OF REIMBURSEMENT CLAIM

☐ Hospitalisation treatment
☐ Day Surgery
☐ Outpatient Cancer Treatment
☐ Outpatient Kidney Dialysis

C. ORIGINAL RECEIPT(S) / BILL(S) SUBMITTED

Receipt/Bill Date	Receipt/Bill No.	Name of Hospital/Clinic	Receipt Amount (RM)
1.			
2.			
3.			
4.			

D. CLAIMANT DETAILS

Full Name			
ID Number		Type of ID	
Mobile No.		Email Address	
Nationality		Relationship	
Correspondence Address			

E. LIFE ASSURED DETAILS

Full Name			
Merchantrade Membership No.		Certificate No.	
ID Number		Type of ID	
Mobile No.		Email Address	
Nationality			
Correspondence Address			

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F. HOSPITALISATION DETAILS

1.	a. Admission: Date / Time		b. Discharge: Date / Time	
2.	If hospitalization was due to accident, please state			
	a. Date and time of accident b. How did the accident occur? c. Nature and extent of injury			
3.	If hospitalization was due to illness, please state			
	a. What were the symptoms presented? b. How long had these symptoms presented before admission to hospital?			
4.	Please provide details of consultations:			
	a. Name and address of doctor/clinic b. The doctor who referred Life Assured to hospital c. All other doctors consulted for this illness d. Name and address of Life Assured's regular treating doctor other than the above			
5.	Is Life Assured presently insured for hospitalization benefits with other companies? If yes, please state ☐ Yes ☐ No			

Names of Insurance Companies	Policy No.	Effective Dates (DD/MM/YYYY)	Amount of Benefits (RM)

G. DECLARATION & AUTHORIZATION

I/ We hereby declare that the forgoing answers are true and accept full responsibility whether they are written by me/ us or someone else on my/ our behalf. I/ We hereby authorize any Hospitals, Clinics, Physician, Medical Staff or other person (within or outside Malaysia, including medical institutions, reinsurers, claim adjusters / investigators, solicitors, industry associations, regulators, statutory bodies, government authorities and credit reporting agencies) who has attended to me/ us to disclose any information including past medical history to MCIS Insurance Bhd in order to process my/ our insurance claim(s).

In compliance with Section 16(3) of the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001 (AMLATFPUAA 2001), MCIS Insurance Berhad reserves its right to withhold or terminate the business application including claims payment where it deems fit and proper.

Signature of Claimant

Name:
ID Number:
Date:

Signature of Witness

Name:
ID Number:
Date:

Disclaimer: MCIS Insurance Berhad may not engage in any transaction or pay claim that would violate any applicable trade, economic and match with any designated sanction. MCIS Insurance Berhad should not be liable to pay any claim or provide any benefit to the extent that the provision of such benefit would expose MCIS Insurance Berhad to any sanction, prohibition or restriction under United Nation resolution or any applicable local laws.

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H. HOSPITALISATION DETAILS

All questions must be answered. Dash (-) is not acceptable. All alterations must be initialed by treating physician.

1.	Patient's Name:	
2.	ID Number:	
3.	a. Admission: Date / Time	b. Discharge: Date / Time
4.	If hospitalization was due to accident, please state	
	a. Date and time of accident b. Nature of accident	
5.	The date on which you first saw the patient for this illness/ injury/ condition	
6.	Was the patient referred to your hospital by any other doctor? If yes, please indicate his/ her name, address and provide a copy of referral letter.	☐ Yes ☐ No Details of referral doctor:
7.	What were the symptoms that patient complained of when he / she first saw you?	
8.	a. According to patient, how long had he / she been experiencing these symptoms b. How long do you think these symptoms had lasted?	
9.	Had patient previously received any treatment for above symptoms? If so, please furnish name, address of doctors and dates of consultation.	
10.	Have any investigation, test or procedure been performed? If so, please furnish the details or certified true copy of the result.	
11.	a. What was your diagnosis? b. Cause and pathology underlying the present diagnosis c. Did you inform the patient of the diagnosis? If yes, please provide date.	
12.	a. Medical treatment given d. Nature of operation(s) performed e. Date surgery performed f. Name of surgeon	
13.	Any possibility of patient having relapse?	☐ Yes ☐ No

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14.	Is the illness/ condition related to the following? If yes, tick (✓)	
	☐	Cosmetic / plastic surgery / routine health screening
	☐	Intoxication / illegal drugs / AIDS / venereal disease
	☐	Self inflicted injury / suicide / attempted suicide
	☐	Congenital / hereditary conditions
	☐	Psychotic / mental disorder/ nervous/sleep disorder
	☐	Hazardous sports/ unlawful act
	☐	None of the above

15. Has the patient previously been treated or hospitalized in this or any other hospital for this or any other disease? Please state:

Date	Disease/Illness	Details of Treatment	Doctor Hospital/Clinic

16. For female patients only

a. Was the patient pregnant at the time of hospitalization? Months	
b. Was illness caused directly or indirectly by pregnancy / child birth / caesarean section / abortion / miscarriage and all complications arising therefrom? Please elaborate.	

I hereby certify that I have personally examined and treated the patient for his/ her injuries/ illness described above and the above answers are all true to the best of my knowledge.

_____ **Signature of Attending Physician**

_____ **Official stamp of Hospital/ clinic**

_____ **Date**

I. CLAIMANT BANK ACCOUNT / MERCHANTRADE MONEY DETAILS

Please provide your Merchantrade Money details for us to accelerate your claims payment process by direct transfer to your Merchantrade Money account.

Merchantrade Money Details	
Name (as per cardholder)	
Last 4 digits of Merchantrade Money Card No.	XXXX - XXXX - XXXX - ___ ___ ___ ___

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