

COVID-19 TEST CLAIM FORM

IMPORTANT NOTES:

- All sections in this form must be fully completed before submission to avoid claim rejection.
- If you have more than one medical and health insurance policy/takaful certificate with different insurance companies and/or takaful operators, please indicate your preferred policy/certificate for verification process.

PART A Details of Policy/ Certificate Holder & Insured/Covered Person
1. Policy/Certificate Number:
2. Name of Insurance Company or Takaful Operator:
3. Policy/Certificate Holder Name (state the name of employer if a group policy/certificate):

4. Insured/Covered Person Name (If other than Policy/Certificate Holder. This includes employee or dependent if insured / covered person under group policy/certificate):

5. Gender Insured/Covered Person :
 Male

 Female

6. Age:
 year

 month

7. Nationality:
8. Insured/Covered Person New / Old NRIC / Passport / Other ID Number:
New NRIC

 -
 -

Old NRIC / Passport / Other ID

9. Home Address:
10. Telephone No:

House:

Office:

Mobile:

PART B COVID-19 Declaration (Please tick where applicable)
11. Have you had any of the following symptoms over the past 14 days?
 Fever Cough Sore throat

 Shortness of breath Other symptoms (please specify)

12. Have you traveled to / resided in any foreign country within 14 days before the onset of illness?
 Yes, please state the country

 No

13. Date of departure from the said country
 - -
14. Have you been in ¹close contact with a ²confirmed case of COVID-19, within 14 days before onset of illness?
 Yes, please state the contact details

 No

15. Have you attended an event associated with known COVID-19 outbreak?
 Yes, please state the event & date

 No

¹close contact defined as:

- Health care associated exposure without appropriate Personal Protective Equipment (including providing direct care for COVID-19 patients, working with health care workers infected with COVID-19, visiting patients or staying in the same close environment of a COVID-19 patient).
- Working together in close proximity or sharing the same classroom environment with a COVID-19 patient.
- Traveling together with COVID-19 patient in any kind of conveyance.
- Living in the same household as a COVID-19 patient.

²confirmed case of COVID-19 defined as a person with laboratory confirmation of infection with the COVID-19

PART C Checklist on Submission of Claim Documents (Please tick (/) one).
 Checklist 1

Declaration by doctor
 I have taken the history and examined the patient and declared the statement provided by the patient above in Part A and Part B are correct.

 The patient is required to take the COVID-19 test not required to take the COVID-19 test

To enclose the following documents

- Original receipt or scan copy of original receipt
- Copy of identity card or passport of claimant as specified in item 4 of Part A.

Doctor's Name, Address & Contact No:

 Checklist 2

To enclose the following documents

- Copy of Doctor's referral letter to indicate you are required to do COVID-19 test
- Original receipt or scan copy of original receipt
- Copy of identity card or passport of claimant as specify in item 4 of Part A.

 Checklist 3

To enclose the following documents

- Copy of Order For Supervision And Observation At Home Form (As per Annex 14a of Guidelines COVID-19 Management in Malaysia No.05/2020 issued by Ministry of Health)
- Original receipt or scan copy of original receipt
- Copy of identity card or passport of claimant as specify in item 4 of Part A.

PART D Payment Details**Payment of Claim is to be made to
(Kindly provide valid payee name)**

Kindly provide the bank account information as follows:

Bank Name:**Bank Account No:****Bank Account Holder Name:****E-mail Address:**

Notes:

- a) You will be notified by email once the payment has been made if you have provided your e-mail address.
- b) Please ensure that the bank account information provided in Part D is accurate and the name matches with the Policy/Certificate Holder/ Insured/Covered Person mentioned in Part A. The Administrator shall not be liable if payments are erroneously credited due to inaccurate account number provided.
- c) No joint name account is allowed.

PART E Declaration and Authorisation

1. I understand and agree that any personal information collected or held by the Administrator (whether contained in this form or otherwise obtained) may be held, used and disclosed by the Administrator to individuals / organisation related to and associated with the Administrator or any selected third party (within or outside of Malaysia, including reinsurance/ retakaful and claims investigation companies and industry associations / federations) for the purpose of processing this application and to communicate with me for such purposes. I understand that I have a right to obtain access to and to request correction of any personal information held by the Administrator concerning me. Such request can be made to my own insurance company or takaful operator.
2. I understand and agree that
 - a) I am allowed to claim this benefit once per life, irrespective of the number of policies/certificates that I have with multiple insurers/takaful operators and is subject to availability of the fund;
 - b) I understand that the Administrator's acceptance of this claim form is not an admission of the Administrator's liability of my/our claim.
 - c) I have read & understood the Terms & Conditions of COVID-19 Test Fund.
3. I hereby request that payment(s) becomes due and payable to me by the Administrator will be paid to the bank account stated above by way of Inter-bank Giro/RENTAS/TT and confirm that :-
 - a) I consent to the Administrator releasing the above data to its banker(s) in order to facilitate payment(s) to me by way of Inter-bank Giro/RENTAS/TT.
 - b) All information provided herein are correct and accurate.
 - c) My request herein shall be irrecoverable without the consent of the Administrator. The Administrator may at any time in its absolute discretion affect payment(s) to me by other mode(s).
 - d) I shall keep the Administrator and its banker(s) indemnified against any loss and/or damage howsoever arising from any matters in relation to Inter-bank Giro/RENTAS/TT requested by me herein including but not limited to error/misdescription in information furnished, delayed payment(s) and any other circumstances beyond the Administrator and its banker(s)'s control.

Note: The disbursement of the Covid-19 Test Fund is jointly administered by Life Insurance Association of Malaysia (LIAM), Persatuan Insuran Am Malaysia (PIAM) & Malaysian Takaful Association (MTA), together with all members of these associations.

I confirm that I am the Policy/Certificate Holder / Insured/Covered Person under the policy/certificate stated above and all information provided herein are correct and accurate.

Name:

Signature:

Date: