Persatuan Insurans Hayat Malaysia
Life Insurance Association of Malaysia

# COVID-19 TEST CLAIM FORM

**IMPORTANT NOTES:**

1. All sections in this form must be fully completed before submission to avoid claim rejection.
2. 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 the verification process.

**For submission of claim for CTF for Patients Requiring Surgery, the additional steps required are as follows:**

3. For item 4 of Part B, you are required to tick (/) Other symptoms and to specify type of surgery.
4. For Part C, you are required to tick (/) Checklist 1 and the Doctor to tick (/) the **Declaration by doctor for surgery confirmation** with the diagnosis. In addition, the Doctor to tick (/) the **Declaration by doctor for COVID-19 test** and **to provide the details i.e.** Doctor's Name, Address & Contact No.
5. Once you have completed the COVID-19 Test Claim Form, please upload the COVID-19 Test Claim Form together with the relevant supporting documents into www.MyCTF.my portal.
6. Detailed Frequently Asked Questions (FAQ) on COVID-19 Test Fund can be accessed through the portal www.MyCTF.my.

## PART A Details of Policy/ Certificate Holder & Insured/Covered Person

| | |
|---|---|
| **1. Policy/Certificate Holder Name** (state the name of employer if a group policy/certificate)**:** | |
| **2. Insured/Covered Person Name** (If other than Policy/Certificate Holder. This includes employee or dependent if insured / covered person under group policy/certificate)**:** | |

| | | |
|---|---|---|
| **3. Insured/Covered Person New / Old NRIC / Passport / Other ID Number:** | **New NRIC** ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐ | **Old NRIC / Passport / Other ID** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ |

## PART B COVID-19 Declaration

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| **4. Have you had any of the following symptoms over the past 14 days? Please tick where applicable** | ❑ Fever ❑ Cough ❑ Sore throat<br>❑ Shortness of breath ❑ Other symptoms (please specify) |
| **5. Have you travelled to / resided in any foreign country within 14 days before the onset of illness?** | ❑ Yes, please state the country<br>❑ No |
| **6. Date of departure from the said country** | ☐☐ - ☐☐ - ☐☐☐☐ |
| **7. Have you been in [1]close contact with a [2]confirmed case of COVID-19, within 14 days before the onset of illness?** | ❑ Yes, please state the contact details<br>❑ No |
| **8. Have you attended an event associated with known COVID-19 outbreak?** | ❑ Yes, please state the event & date<br>❑ No |

[1]close contact defined as:

a) 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 COVID19 patient).
b) Working together in close proximity or sharing the same classroom environment with a COVID-19 patient.
c) Travelling together with COVID-19 patient in any kind of conveyance.
d) Living in the same household as a COVID-19 patient.

[2]confirmed 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

**OR**

**Declaration by doctor for surgery confirmation**

❑ I have taken the history and examined the patient and declared that the patient is required to undergo the emergency[3] / semi-emergency[4] surgery with the following diagnosis:

_____

_____

Note: The following definition is based on the Emergency Severity Index from the Agency for Healthcare Research and Quality (an agency of the US Department of Health and Human Services):

[3]Emergency means a situation where a patient requires immediate and life-saving intervention

[4]Semi-Emergency or urgent means a high-risk patient whose condition could easily deteriorate or who presents with symptoms of a condition requiring time-sensitive treatment

**Declaration by doctor for COVID-19 test**

❑ 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 | Doctor's Name, Address & Contact No: |
|---|---|
| 1. Original receipt or scanned copy of original receipt<br>2. Copy of identity card or passport of claimant as specified in item 2 of Part A | |

❑ Checklist 2

**OR**

To enclose the following documents

1. Copy of Doctor's referral letter to indicate that you are required to do a COVID-19 test
2. Original receipt or scanned copy of original receipt
3. Copy of identity card or passport of claimant as specified in item 2 of Part A.

❑ Checklist 3

To enclose the following documents

1. 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)
2. Original receipt or scanned copy of original receipt
3. Copy of identity card or passport of claimant as specified in item 2 of Part A.

**PART D 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 request to update and correct 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 claim.
   c) I have read & understood the Terms & Conditions of COVID-19 Test Fund.

**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: |
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