PRE-AUTHORISATION FORM / Borang Pra-kebenaran

Private and Confidential / Sulit dan Persendirian

Etiqa Healthcare Call Centre: 1800 88 9998 | Etiqa Healthcare Fax: 1800 22 9988

Part 1 (To be completed by Patient / Claimant)
Bahagian 1 *(Untuk diisi oleh Orang yang Menuntut)*

1. Patient Name: *Nama Pesakit*	2. NRIC (Old & New): *K.P. (Lama & Baru)*
3. a. Date of Birth: *Tarikh lahir* b. Age: *Umur*	c. Sex: ☐ Male *Laki-laki* ☐ Female *Perempuan*
4. Policy No./ Member ID/ Certificate No./ Plan/ Company Name: *No. Polisi/ No. Ahli/ No. Sijil / Pelan/ Nama Syarikat*	5. Admission / Planned Admission Date: *Tarikh kemasukan hospital*
6. Hospital Name: *Nama Hospital*	7. Name of Attending Doctor/ Speciality: *Nama Doktor yang Merawat/ Kepakaran*

Admission Reason Please tick (✓) and answer accordingly
Sebab Kemasukan *Sila tanda (✓) dan jawab soalan yang berkenaan*

☐ 8. Accident *Kemalangan*	a. Occurred on: *Berlaku pada* Date _____/_____/_____ *Tarikh* Time _____ *Masa* ☐ am *pagi* ☐ pm *petang* b. Details of Accident: *Butir-butir kemalangan*
☐ 9. Illness *Penyakit*	a. Symptoms first appeared on: *Simptom tersebut bermula pada* Date _____/_____/_____ *Tarikh* b. Doctor(s) consulted for this condition: *Doktor-doktor yang dirujuk bagi penyakit ini* c. Doctor's or Clinic Contact (Address & Telephone): *Alamat & Telefon Doktor*

Goods and Services Tax (GST) Information Please tick (✓) and answer accordingly
Maxlumat Cukai Barangan dan Perkhidmatan *Sila tanda (✓) dan jawab soalan yang berkenaan*

10. Are you GST registered? Adakah anda berdaftar di bawah GST? ☐ Yes / *Ya* ☐ No / *Tidak*

If "Yes", please provide your GST Registration Number: *Sekiranya "Ya", sila nyatakan nombor pendaftaran GST anda*

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Etiqa Insurance Berhad and Etiqa Takaful Berhad's (hereinafter both referred to as "ETIQA") shall rely on the above information provided by you for tax credit purposes provided under the GST Act. ETIQA shall not be liable for any liability or any fine, charge or penalty as a result of relying on your incorrect advice. Should action be taken against ETIQA and/ or penalties be imposed on ETIQA by any tax authority or relying on the same, ETIQA reserves its right to be indemnified by you to the fullest extent permitted by law and any GST liability arising from your incorrect advice shall be payable by you.

Etiqa Insuran Berhad and Etiqa Takaful Berhad (selepas ini kedua-duanya dirujuk sebagai ("ETIQA") akan bergantung kepada maklumat yang anda berikan untuk kredit cukai yang diperuntukkan di bawah Akta GST. ETIQA tidak bertanggungjawab terhadap sebarang liabiliti atau denda, penalti atau caj jika maklumat yang diberikan oleh anda tidak betul. Sekiranya tindakan dan/ atau penalti dikenakan ke atas ETIQA oleh mana-mana pihak berkuasa, ETIQA berhak menuntut kerugian daripada anda sehingga tahap yang dibenarkan oleh undang-undang dan sebarang liabiliti GST yang wujud berdasarkan maklumat yang tidak betul.

11. Declaration and authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I understand the delivery of this form is in no way an admission of Etiqa Insurance Berhad and Etiqa Takaful Berhad's (hereinafter both referred to as "ETIQA") liability and payment to the hospital by ETIQA or its representative shall not be construed as final admission of ETIQA's liability and for this and any further claims arising, ETIQA reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my/ the Assured/ the Insured/ the covered medical insurance/ takaful under the above-mentioned Policy/ Certificate. I hereby undertake to settle/ reimburse any medical expenses exceeding my entitlement under the said policy contract/ takaful certificate, or that is not covered by the same.

I hereby irrevocably authorize any organisation, institution, or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident/ injury, to disclose to ETIQA or its representative such information. I agree that ETIQA or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including ETIQA's parent company, subsidiaries or any other associated companies within ETIQA's Group, reinsurers, medical examiners, claims investigators and industry associations/ federations etc.) in relation to this claim. This authorization shall bind my/ the Assured's/ the Insured's/ the Covered's successors and assigns and remain valid notwithstanding my/ Assured's/ the Insured's/ the Covered's incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original.

I agree that in the event I make, or have in the past made, any false or untrue statement and/ or suppressed and/ or concealed any material facts in respect of my/ the Assured/ the Insured's/ the Covered's condition, ETIQA shall absolutely forfeit my/ the Insured's/ the Assured's/ the Covered's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof. ETIQA values your data privacy rights and is committed to complying with the Personal Data Protection Act 2010. Please read our Privacy Notice which can be found at www.etiqa.com.my or at any of our branches for details on how we collect, use, process, protect and disclose your personal data.

Pengisytiharan dan pemberikuasa

Saya mengisytiharkan bahawa jawapan-jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti Etiqa Insuran Berhad and Etiqa Takaful Berhad (selepas ini kedua-duanya dirujuk sebagai ("ETIQA") dan bayaran kepada hospital oleh ETIQA atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti ETIQA dan ETIQA berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had insurans/ takaful perlindungan perubatan saya di bawah Polisi/ Sijil yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang perbelanjaan perubatan yang melebihi had kelayakan saya di bawah kontrak polisi/ sijil takaful tersebut atau yang tidak dilindungi oleh insurans/takaful berkenaan.

Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya/ Assured/ Insured, yang telah atau mungkin akan dirujuk supaya mendedahkan kepada ETIQA atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan ETIQA atau wakilnya untuk menggunakan dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkait dalam ETIQA, reinsurer, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya/ orang yang diinsuranskan/ orang yang dilindungi dan kekal sah meskipun setelah kematian saya/ orang yang diinsuranskan/ orang yang dilindungi setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah sepertimana yang asal.

Saya bersetuju sekiranya saya membuat pengakuan palsu atau pernyataan yang tidak benar dan/ atau tidak mendedahkan dan/ atau menyembunyikan maklumat yang berkaitan dengan keadaan saya/ orang yang diinsuranskan/ orang yang dilindungi, ETIQA berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar. ETIQA hargai hak data peribadi anda dan komited untuk mematuhi Akta Perlindungan Data Peribadi 2010. Sila rujuk kepada Notis Privasi kami yang boleh didapati di www.etiqa.com.my atau mana-mana cawangan kami mengenai cara kami mengumpul, menggunakan, memproses, melindungi dan mendedahkan data peribadi anda.

Signature of Patient / *Tandatangan Pesakit*	Signature of Policyholder / Certificate Holder / Claimant *Tandatangan Pemilik Polisi / Pemilik Sijil / Orang yang Menuntut*	Signature of Witness / Tandatangan Saksi
_____	_____	_____
Full Name / *Nama Penuh*:	Full Name / *Nama Penuh*:	Full Name / *Nama Penuh*:
IC No. / *No. KP*:	IC No. / *No. KP*:	IC No. / *No. KP*:
Date / *Tarikh*:	Date / *Tarikh*:	Date / *Tarikh*:
Contact No. / *No. Telefon*:	Contact No. / *No. Telefon*: Relationship with Patient / *Hubungan dengan Pesakit*:	Contact No / No untuk dihubungi:

NOTE: COMPLETION OF THIS PRE AUTHORISATION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
NOTA: PENYEMPURNAAN BORANG PRA-KEBENARAN INI TIDAK MENJAMIN BAHAWA SURAT JAMINAN AKAN DIKELUARKAN.

Part 2 ADMISSION SECTION *(To be completed upon admission by Doctor)*

1.a. Patient name: b. NRIC: c. Age: d. Sex: ☐ Male ☐ Female

2. Policy No./ Member ID/ Certificate No./ Plan/ Company No:

3. Admission No./ MRN and Hospital Name/ Hospital Contact and Fax No :

4. Admission Date and Time:

5. Expected days of stay/ Discharge Date:

6. a. Symptoms/ Conditions requiring admission:

b. How long is patient aware of the condition:

c. Patient's BP/ Temp/ Pulse:

d. Date symptoms first appeared: _____/_____/_____

e. Date first consulted: _____/_____/_____

7. a. Any previous consultation/ treatment/ hospitalization for this symptom/ illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No

b. Was this patient referred? If Yes, please provide details below:

c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed :

Date	Disease/ Disorder	Details of Treatment/ Hospitalization	Doctor / Hospital/ Clinic

d. Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
If no please provide reasons of admission :

8. a. ☐ Admitting Diagnosis:
or
b. ☐ Provisional Diagnosis:

c. Diagnosis confirmed on _____/_____/_____
Advised patient on _____/_____/_____

d. Cause and pathology underlying the present diagnosis:

9. Estimated Total Costs : RM _____

e. Any possibility of relapse? ☐ Yes ☐ No

10.a. Admission requires:
- ☐ Hospitalisation
- ☐ Day Care
- ☐ On Patient's Request

11. Is the illness/ condition related to: (please tick ✓ if YES) Please provide details:
- a) ☐ Pregnancy/ Childbirth/ Infertility/ Caesarean section/ miscarriage Or any complications arising therefrom.
- b) ☐ Congenital / Hereditary diseases
- c) ☐ Influence of Drugs / Alcohol
- d) ☐ Nervous / Mental / Emotional / Sleeping Disorder
- e) ☐ Cosmetic reason / Dental care / refractive errors correction
- f) ☐ AIDS / STD / VD/ HIV
- g) ☐ Self-inflicted injuries / Violation of laws / Strike / Riots
- h) ☐ None of the above

12. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):

13. Any other medical/surgical conditions present? ☐ No ☐ Yes, details below:
a. _____ since _____/_____/_____
b. _____ since _____/_____/_____

14. Was the patient pregnant at the time of hospitalization? (For Female Only)
☐ No ☐ Yes, _____ months

15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:

b. Please indicate date/time of accident: (dd/mm/yy) _____/_____/_____ (hrs) _____ ☐ am ☐ pm

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

Date | Name & Signature of Attending Doctor | Doctor/ Hospital Stamp

DISCHARGE SECTION *(To Be Completed Upon Discharge by Doctor)*

17. Undertaking Letter Ref No. *(If available)*:

18. Date of Discharge:

19. a. Final Diagnosis:

b. Cause and pathology of the diagnosis:

ICD code:

20. Treatment given / Investigation done: (Please supply copy of all investigation results)

21. a. Surgical procedures performed:

b. Date of surgery / procedure:

MMA code / PHFSR code:

22.a. Recovery complication that arose (if any):

b. In the case of DEATH, please advise Date/ Time and Cause of death :

23. I hereby certify that I have personally examined and treated the Patient for his/her injuries/illness described above and that the facts as state above represent my medical opinion of his/her condition.

Date | Name & Signature of Attending Doctor | Doctor/ Hospital Stamp