CRITICAL ILLNESS CLAIM FORM

This form must be completed truthfully and accurately. If the space is not enough or no applicable field available, please supplement information by attachment. The list of documents required is not exhaustive and we reserve the right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned to us together with all supporting documents as soon as possible at the following address:

AIG Malaysia Insurance Berhad (200701037463)
Claims Department, Level 16
Menara Worldwide, 198 Jalan Bukit Bintang, 55100 Kuala Lumpur, Malaysia
Telephone : 1 800 88 8811
Facsimile : 603 2685 4896
Email address : mypaclaims@aig.com
www.aig.my

Section I – General Information (REQUIRED)

Policy/Certificate No. :	Name of Policyholder (as per NRIC / Certificate of Incorporation) :	
Name of Insured (as per NRIC / Certificate of Incorporation) :		Insured's NRIC No/Passport No.:
Name of Claimant (as per NRIC /Certificate of Incorporation) : (Only applicable for fatal case)	Claimant's NRIC No./Passport No. :	Relationship between Claimant & Insured :
Name of Parent/Legal Guardian (Only applicable if the Insured is below the age of 18) :		Parent/Legal Guardian's NRIC No. /Passport No. :
Claimant's E-mail Address :	Claimant's Mobile Phone No. : Acknowledgement will be sent to this mobile phone number via SMS upon receipt of this form.	Insured's Occupation :
Mailing Address :		
Are you a citizen of the United States? ☐ Yes ☐ No	If yes, please provide your social security number :	

AIG Malaysia Insurance Berhad (200701037463) is a subsidiary of U.S. company and as such is required to report injury claims of U.S. citizens who may be eligible to receive "Medicare" (pursuant to the Medicare, Medicaid & SCHIP Extension Act of 2007). This information is requested solely to enable us to comply with this reporting requirement.

Claim Type (please tick) : ☐ New Claim ☐ Further Claim, with Claim Number : ____________________

Claim Item (please tick) :				
Amount RM ____________	☐ Outpatient Medical Expense	☐ Critical Illness	☐ Broken Bone	☐ Weekly Indemnity
	☐ Hospital Income	☐ Permanent Disability	☐ Other, please specify: ____________	
	☐ Hospital Expenses	☐ Accidental Death		

Do you have any other insurance policies covering this loss or expenses incurred? ☐ Yes ☐ No	If yes, please provide the details below Name of Insurer : ____________ Policy No. : ____________ Policy Type : ____________ Sum Insured : ____________

Bank Details for E-Payment

Account Holder's Name (Must be the Insured or Insured's Parent/ Legal Guardian if the Insured is below the age of 18) :	Bank Name :
E-mail Address (if different from above) : Notification of payment will be sent to this email address	Account Number :

Section II – Details of Injury / Sickness / Incident

Date and time of the injury/sickness/Incident : DD MM YYYY ☐ ☐ A.M. / P.M.	Date of first consultation with doctor/hospital : DD MM YYYY	Nature of injury/Diagnosis of sickness/Incident :
In the case of injury, where and how did the accident occur? In the case of sickness, what were the symptom(s) and when did the symptom(s) first appear?		
Part of body affected :	Name of the attending doctor :	Address of where the patient is treated :
Name of Witness(es) (Applicable to Injury Claim) :	Address of witness(es) (Applicable to Injury Claim) :	Contact number of witness(es) (Applicable to Injury Claim:)
Was the injury due to any other person's fault? ☐ Yes ☐ No	If yes, please provide name, address and contact number of this third party(s):	
Did this accident occur in the course of and/or arising out of employment? ☐ Yes ☐ No	If yes, please state the name of the insurance company for Workmen's Compensation Insurance and the Policy no.	Period of sick leave granted by attending physician From DD MM YYYY To DD MM YYYY
Do you need to receive further medical treatment? ☐ Yes ☐ No	If yes, how long will the further medical treatment last?	

Section III – Declaration and Authorization

I/We do solemnly declare that the forgoing particulars are true and correct in every detail. I/We agree that if I/We have made or, in any further declaration in respect of the said claim, if I/We shall made any false or fraudulent statements or suppress, omit to disclose, or falsely state any material fact whatsoever, this claim shall be voided and all rights of recovery in connection with this claim shall be forfeited.

I/We hereby authorize any person, institution, physician, clinic, hospital, or medical practitioner who has attended to me/the insured person to provide and disclose to AIG Malaysia Insurance Berhad ("AIG Malaysia") the full particulars about my health condition, medical history and medical records (including as a result of this hospitalization/surgery).

I/We agree and consent, that for purposes of administering and assessing the claim provided in this form and any other claim related matters, AIG Malaysia may collect, use and process my/our personal information (whether obtained in this form or otherwise obtained) and disclose such information in accordance with the Company's Privacy Notice found at https://www.aig.my/privacy-notice.

If I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG Malaysia, I have informed the individual(s) about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG Malaysia, and the individual(s) agrees and consents that AIG Malaysia may collect, use and process his/her personal information (whether obtained in this form or otherwise obtained) and disclose such information in accordance with the Company's Privacy Notice found at https://www.aig.my/privacy-notice, for purposes of administering and assessing the claim provided in this form and any other claim related matters.

I/We declare and confirm that all information provided are full, complete, true and accurate. I hereby authorize AIG Malaysia to release payment via direct credit or GIRO to the above Bank Account. I further understand that AIG Malaysia relies on the above information and instruction in order to make payment and in the event of any loss arising from this payment, AIG Malaysia is absolved from any or all liability.

Signature of Claimant	Signature of Policy Holder/ Insured Person and Company Rubber Stamp	Date Signed ☐☐ - ☐☐ - ☐☐☐☐ *Day* *Month* *Year*

For all intents and purposes where there is a conflict or ambiguity as to the meaning in the English provisions or the Bahasa Malaysia provisions, it is hereby agreed that the English version will prevail.