



redefining / standards

**AXA Affin General Insurance Berhad** (23820-W)

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GST Reg. No. : 000709398528

# Personal Accident Claim Form

Policy/ Certificate No.

To expedite your claim, please (1) complete this form, (2) prepare the relevant documents required in Page Two and (3) submit them to AXA Office as soon as possible. Thank you.

## A. POLICY DETAILS

Policyholder/Insured's Full Name			
Office/Mobile No.		Email	
Correspondence Address			
GST-registration No. (If registered)		Date of registration	

## B. CLAIMANT DETAILS (if other than above)

Full Name			
Mobile No.		Relationship	

## C. ACCIDENT & INJURY DETAILS

Date and Time of Accident	Date :	Location of Accident		
	Time :			
Type of loss/claim	<input type="checkbox"/> Medical Expenses	<input type="checkbox"/> Total Permanent Disablement	<input type="checkbox"/> Others (Please specify)	
	<input type="checkbox"/> Temporary Partial Disablement	<input type="checkbox"/> Accidental Death		
	<input type="checkbox"/> Temporary Total Disablement			
Description of Accident				
Description of Injury Sustained (e.g. body part injured, injury type)				Have you injured the same part before?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Date on which you resumed duty?				
Have you made a claim against any other party in respect of this event? If yes, please provide details	Name of other party / insurance company :			
	Description of claim :			

## D. BANK ACCOUNT DETAILS

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

Name (as per bank account)		Bank Name	
Account No.		Bank Branch	

**Note:** Claim payment via Direct Credit is within 3 working days whereas cheque will be processed within 14 working days subject to receipt of all documentations required.

## E. DECLARATION & CUSTOMER'S DATA PRIVACY NOTICE

**[Declaration]** I/We hereby declare that the above statements and facts are true, copies of documents are identical with the original one, and that I/We have not withheld from the Company, any information within my/our knowledge connected with the accident.  
**[Customer's Data Privacy Notice]** AXA Affin General Insurance Berhad is committed to protect the personal data submitted by and collected from you. For further details, please refer to our "Data Privacy Notice" published in our website.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Insured / Claimant


## F. DOCUMENTS REQUIRED FOR CLAIM SETTLEMENT

Below is a list of minimum documentation required to process your claim. In certain circumstances, additional information *may* be required in order for further confirmation.

<b>Documents Required</b> <i>(Please tick against the documents you have submitted)</i>
<input type="checkbox"/> Medical Certificates
<input type="checkbox"/> Original Hospital/ Medical Bills & Receipts
<input type="checkbox"/> Medical Reports
<input type="checkbox"/> Inpatient Discharge Summary – <i>for hospital income benefit claim only</i>
<input type="checkbox"/> Police Report/ Accident Report – <i>for motor accident injury claim or criminal incident</i>
<input type="checkbox"/> Employment Letter & 3-month salary slips ( <u>for Group PA on un-named basis only</u> )
<b>For Fatal Accident – in addition to above:</b>
<input type="checkbox"/> Certified True Copy (CTC) of Death Certificate / Post-Mortem Report / Burial Certificate
<input type="checkbox"/> CTC of Deceased's NRIC / <u>Employment Letter &amp; 3-month salary slips (for Group PA only)</u>
<input type="checkbox"/> CTC of Letter of Administration / Distribution Order ( <i>only if un-named beneficiary for individual policy</i> )

## G. TRACK YOUR CLAIM STATUS

Once your claim is registered, you will be updated through email. If you have any enquiries on your claim, please reach us at:

 **Claims Customer Service Centre**  
AXA Affin General Insurance Berhad  
Level 26, Wisma Goldhill,  
67, Jalan Raja Chulan, 50200 KL

 **+03 2170 8282**  
(Press 3 for Claims)

 **claims@axa.com.my**

**AXA is committed to making your personal accident insurance claim process as easy as possible. Thank you for insuring with us. We are always glad to be of your service.**

# Medical Report

## Private & Confidential

This form is to be completed by the Patient's Attending Doctor.  
The cost of this medical report is to be borne by the Claimant.

1.	Full Name of Patient (= Claimant)				Date of Accident (DD MM YY)	
2.	Cause of Injury					
3.	Nature and Extent of the Injury <i>Describe complications, if any</i>	Final Diagnosis	Part of Body (State Left/Right limb)		Symptoms	
4.	Date You First Consulted For This Injury/Condition (DD MM YY)			Date of Hospitalization, <i>if applicable</i> (DD MM YY)	Admitted	Discharged
	Treatment(s)	Completed	Ongoing	Other Treatments, <i>if any</i>	Completed	Ongoing
	<input type="checkbox"/> X-ray	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Surgery	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Special Diagnostics	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
5.	How long has the Patient been disable from engaging in or attending to usual employment or occupation as a result of these injuries?	Totally	From: _____ To: _____			
		Partially	From: _____ To: _____			
6-1.	Any Sign of Pre-Existing Injury? <i>If yes, please provide details (Nature &amp; Cause of Injury/ Symptom)</i>					Date Treated <i>Estimated MM/ YY</i>
6-2.	Do you think current accident aggravated injury? <i>If yes, please provide reasons for your opinion</i>					
7.	At the time of accident, was the patient suffering from any illness? <i>If yes, please provide details</i>					
8.	Details of any circumstances which may have contributed to the accident and/or lengthen the period of disability. <i>(e.g. physical impairments, medical history or intoxication)</i>					
9.	Any other information or professional advice that should be made known to AXA?					

I hereby certify that the above-named met with accident referred to, and that the foregoing statements are correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Treating Doctor/ Specialist

\_\_\_\_\_  
Date

<p>Official Stamp of Hospital/ Clinic</p>
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