FWD takaful

RELEASE OF INFORMATION

CLAIM

FWD TAKAFUL BERHAD

Certificate No :

Covered Person :

NRIC No :

CONSENT:

I, the undersigned, hereby authorize and give consent to any physician, hospital, clinic that has any records or knowledge of Covered Person's health to disclose to **FWD TAKAFUL BERHAD and/or its representative,** for the purpose of Takaful claims application. I hereby declare that the physician, clinic, hospital and its employees are not responsible or liable in any way whatsoever, for usage other than stated above, of herein released medical information. A photo copy of this authorization shall be as effective and valid as the original.

ATTENDING DOCTOR ***(to be completed by Claims Department)***

Name of Attending Doctor: _____

Clinic /Hospital Name: _____

Address: _____

Telephone No: _____

_____
Signature of Covered Person

Name: _____

NRIC: _____

Date: _____

_____
Signature of Witness

Name : _____

NRIC : _____

Date : _____

_____
Signature of Claimant / Next of Kin

Name: _____

NRIC: _____

Date: _____

***Note : For Total and Permanent Disability claims and Critical Illness claims for which the Covered Person is terminally ill : If, due to Disability/condition, the Covered Person is not able to complete the Forms/documents required to be completed him/her, claimant/next of kin may assist to complete the form and sign as the witness. Signature of the Covered Person may imprint his/her thumb print.**

This is an auto generated letter. No signature is required.