CONSENT LETTER

To: _____ Date: _____

_____

_____

_____

Dear Sir/Madam,

NAME OF PATIENT: _____

AUTHORIZATION TO OBTAIN MEDICAL REPORT AND OTHER INFORMATION

The above named was treated at your hospital/clinic as an inpatient/outpatient during the period of _____

to _____. In connection with the insurance claim which I have submitted to the Company,

I, _____ (NRIC No. : _____) hereby in my capacity as the

☐ Claimant

☐ Deceased's next-of-kin

(For Death only, please state the relationship to Deceased: _____)

to give consent to:

1. The Company to hold, use or disclose my/deceased's personal information to any hospital, clinic, physician, specialist, insurance or reinsurance companies, professional adviser or bodies, Life Insurance Association of Malaysia (LIAM), Ombudsman for Financial Services (OFS), Insurance Services of Malaysia (ISM), organization, institution or person(s) and authorized agents or representatives for the purpose of processing this form.

2. Any hospital, clinic, physician, specialist, insurance or reinsurance companies, professional adviser or bodies, Life Insurance Association of Malaysia (LIAM), Ombudsman for Financial Services (OFS), Insurance Services of Malaysia (ISM), organization, institution or person(s) and authorized agents or representatives to hold, use or disclose my/deceased's personal information to the Company and/or its authorized representatives for the purpose of processing this form.

_____

Signature of Life Assured / Claimant

Name : _____
NRIC No. : _____
Tel. No. : _____
Address : _____
_____

_____

Signature of Witness

Name : _____
NRIC No. : _____
Tel. No. : _____
Address : _____
_____

_____

Signature of Deceased Next-of-kin

Name : _____
NRIC No. : _____
Tel. No. : _____
Address : _____
_____

_____

Signature of Witness

Name : _____
NRIC No. : _____
Tel. No. : _____
Address : _____
_____

SURAT KEBENARAN

Kepada: _____ Tarikh: _____

_____

_____

_____

Tuan/Puan,

NAMA PESAKIT: _____

PEMBERIAN KUASA UNTUK MEMPEROLEHI LAPORAN PERUBATAN DAN MAKLUMAT LAIN

Pesakit yang disebutkan seperti di atas telah menerima rawatan di hospital/klinik tuan/puan sebagai pesakit dalam/pesakit luar dari _____ hingga _____. Berhubung dengan tuntutan insurans yang telah saya serahkan kepada pihak Syarikat, saya, _____ (No. K/P : _____) sebagai

☐ Pihak Menuntut

☐ Waris Simati

(Bagi tuntutan kematian, sila nyatakan hubungan dengan SiMati: _____)

memberi kuasa kebenaran kepada:

1. Pihak Syarikat untuk memegang, menggunakan atau mendedahkan maklumat peribadi saya/simati kepada mana-mana hospital, klinik, pegawai perubatan, doctor pakar, syarikat insurans atau insurans semula, penasihat atau badan professional, Persatuan Insurans Hayat Malaysia (LIAM), Ombudsman Perkhidmatan Kewangan (OFS), Insurance Services Malaysia Berhad (ISM), organisasi, institusi atau pihak dan ejen-ejen berdaftar atau wakil-wakil bagi tujuan pemprosesan permohonan ini.

2. Mana-mana hospital, klinik, pegawai perubatan, pakar perubatan, syarikat insurans atau insurans semula, penasihat atau badan profesional, Persatuan Insurans Hayat Malaysia (LIAM), Ombudsman Perkhidmatan Kewangan (OFS), Insurance Services Malaysia Berhad (ISM), organisasi, institusi atau pihak dan ejen-ejen yang dibenarkan atau wakil-wakil untuk memegang, menggunakan atau mendedahkan maklumat peribadi saya/simati kepada Pihak Syarikat dan/atau wakil-wakil berdaftar bagi tujuan pemprosesan permohonan ini.

_____

Tandatangan Orang yang Diinsuranskan/Pihak Menuntut

Nama : _____
No. K.P. : _____
No. Tel. : _____
Alamat : _____
_____

_____

Tandatangan Saksi

Nama : _____
No. K.P. : _____
No. Tel. : _____
Alamat : _____
_____

_____

Tandatangan Waris Simati

Nama : _____
No. K.P. : _____
No. Tel. : _____
Alamat : _____
_____

_____

Tandatangan Saksi

Nama : _____
No. K.P. : _____
No. Tel. : _____
Alamat : _____
_____

FWD Insurance Berhad 199301022976 [277714-A]
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