



LONPAC INSURANCE BHD (307414-T)

Head Office : LG, 6th, 7th, 21st to 26th Floor, Bangunan Public Bank, 6, Jalan Sultan Sulaiman, 50000 Kuala Lumpur, Malaysia.
P.O. Box 10708, 50722 Kuala Lumpur, Malaysia.
Tel: (03) 2262 8688, 2723 7888 Fax: (03) 2715 1332, 2034 2654, 2715 0722, 2072 3385, 2715 0696, 2723 7886
Website: www.lonpac.com

NOTICE OF CLAIM UNDER PERSONAL ACCIDENT POLICY NOTIS TUNTUTAN DIBAWAH POLISI KEMALANGAN PERIBADI

N.B. The issue of this Form is not an admission of liability by the Company.
This Form must be fully completed and returned to the Company.

N.B. Pengeluaran Borang ini bukan pengakuan liabiliti oleh Syarikat.
Borang ini mesti diisi penuh dan dikembalikan kepada Syarikat.

Policy No. / No. Polisi : _____

Claim No. / No. Tuntutan : _____

DETAILS OF INSURED / BUTIR-BUTIR PEMEGANG POLISI

1. Name of Insured Nama Pemegang Polisi	:		
2. Address Alamat	:		
3. Telephone No No. Telefon	:	(O)	4. Handphone No. No. Telefon Bimbit
	:	(H)	
5. Email Address Alamat Emel	:	6. Occupation Pekerjaan	
7. Name of Employer Nama Majikan	:		
8. Nature of business (if self employed) Jenis perniagaan (jika perniagaan sendiri)	:		

1. Name of Injured Person Nama Tercedera	:		
2. Address Alamat	:		
3. I.C. No. No. Kad Pengenalan	:		
4. Handphone No. No. Telefon Bimbit	:		
5. Telephone No. No. Telefon	:	(O)	6. Email Address Alamat Emel
	:	(H)	
7. Age Umur	:	Sex : Jantina:	Marital Status : Taraf Perkahwinan:
	:	<input type="checkbox"/> Male Lelaki	<input type="checkbox"/> Married Kahwin
	:	<input type="checkbox"/> Female Perempuan	<input type="checkbox"/> Single Bujang
8. Occupation Pekerjaan	:	<input type="checkbox"/> Divorced Bercerai	
9. Date of Accident Tarikh Kemalangan	:	<input type="checkbox"/> Widow/Widower Janda/Duda	Time: Masa:
10. Place of Accident Tempat Kemalangan	:		

<p>11. Describe in detail : How the accident occurred ? <i>Terangkan dengan jelas bagaimana kemalangan berlaku ?</i></p>	
<p>12. State what you were doing at the time of accident ? <i>Nyatakan apakah yang anda sedang lakukan pada masa kemalangan ?</i></p>	
<p>13. Describe in detail the injury suffered by you ? <i>Nyatakan dengan jelas kecederaan yang dialami oleh anda ?</i></p>	
<p>14. Name and Address of any Person who sent you to Hospital ? <i>Nama dan alamat sesiapa yang membawa anda ke Hospital ?</i></p>	
<p>15. Name and Address of any Person who witnessed the accident ? <i>Nama dan Alamat sesiapa yang menyaksikan kemalangan itu ?</i></p>	
<p>16. Nama and Address of Medical Practitioner who attended to you after the accident ? <i>Nama dan Alamat Pegawai Perubatan yang dijumpai selepas kemalangan ?</i></p>	
<p>17. Are you entitled to receive compensation from any other Insurers in respect of this Injury ? If so, please state : <i>Adakah anda layak menerima pampasan dari syarikat-syarikat insuran yang lain berkaitan dengan kecederaan ini ? Jika ya, nyatakan :</i></p> <p>a) Name of Insurance Company ? <i>Nama Syarikat Insuran ?</i></p> <p>b) Amount you are insured for ? <i>Jumlah anda diinsuran ?</i></p>	

DECLARATION / PERAKUAN

I/We hereby declare the foregoing particulars to be true in every aspect and that no information has been suppressed.
Saya/Kami mengaku bahawa butir-butir diatas adalah benar dari semua segi dan tiada maklumat yang diilindungi.

Date: _____
Tarikh:

Signature of Claimant / *Tandatangan Penuntut*
(Company chop where applicable)
(*Chop Syarikat dimana perlu*)

MEDICAL CERTIFICATE SIJIL PERUBATAN

The Claimant must obtain at his own expense the following certificate from a registered Medical Practitioner. The Medical Practitioner is requested to complete in detail this Certificate.
Penuntut hendaklah mendapati sijil dibawah atas tanggungan sendiri daripada Pegawai Perubatan yang berdaftar. Pegawai Perubatan diminta mengisi dengan penuh Sijil ini.

<p>1. Name of Injured Person / <i>Nama Tercedera</i> I.C. No.: / <i>No. Kad Pengenalan:</i></p>	
<p>2. The date you first attended to the injured person in respect of the injuries sustained <i>Tarikh anda mula mengubati tercedera berkaitan dengan kecederaan yang dialami</i></p>	
<p>3. Are the injuries sustained consistent with the Accident as described on the previous pages of this form? <i>Adakah kecederaan ini serasi dengan kemalangan seperti diterangkan di muka sebelah?</i></p>	
<p>4. How long the claimant has been confined as a result of the accident above referred to <i>Tempoh penuntut adalah dihadkan akibat dari kemalangan yang dirujuk</i></p> <p>(a) To his bed / <i>Kepada katilnya</i> (b) To his house / <i>Kepada kediamannya</i></p>	<p>(a)</p> <p>(b)</p>
<p>5. Full particulars of injuries caused by the accident <i>Maklumat penuh kecederaan yang disebabkan oleh kemalangan</i></p>	
<p>6. Whether claimant is now or was at the time of the accident suffering from any physical defect or illness irrespective of his injuries. If so please state nature thereof. <i>Samada penuntut sekarang atau sebelum kemalangan mengalami sebarang kecederaan fizikal atau penyakit. Jika ya, terangkan.</i></p>	
<p>7. If still confined to bed or house, probable further period he will be so confined? <i>Jika masih dihadkan pada katil atau rumah, jangkamasa selanjutnya?</i></p>	
<p>8. (a) To what extent the Claimant has been or will be totally disabled from following his occupation as shown on the previous page of this form. <i>Setakat mana penuntut telahpun atau akan tidak berupaya penuh akibat daripada seperti diterangkan dimuka sebelah.</i></p> <p>(b) To what extent the Claimant has been or will be partially disabled from following his occupation as shown on the previous page of this form. <i>Setakat mana penuntut telahpun atau akan tidak berupaya separa akibat daripada seperti diterangkan dimuka sebelah.</i></p>	<p>_____</p> <p>_____</p>
<p>9. Whether the Claimant is now attending to his business or occupation in any way? <i>Samaada penuntut masih bekerja?</i></p>	

I hereby certify the foregoing statements are correct.
Saya dengan ini mengesahkan bahawa butir-butir diatas adalah benar.

SIGNATURE

TANDATANGAN

ADDRESS

ALAMAT

QUALIFICATIONS

DATED

BERTARIKH

KELAYAKAN



ELECTRONIC CREDIT PAYMENT (ECP) AUTHORISATION FORM

- Kindly provide us with the following details / documents for payment via ECP

Terms & Conditions

- 1 A copy of the Beneficiary(ies) bank statement/first page of bank passbook with account details, is to be attached together with this Electronic Credit Payment Form. The Company reserves the right to request for further and other documents to support this request for Electronic Credit Payment.
- 2 Payment under this Electronic Credit Payment shall be credited to the **active** bank account of the Beneficiary(ies), as stated herein.
- 3 Electronic Credit Payment is only available for direct credit to banks participating in the Interbank Giro payment system (IBG).
- 4 Electronic crediting of claims payment into the following accounts are not allowed:
 - (a) Overseas bank account; and
 - (b) Any local bank account that is not in the name of the Beneficiary(ies) as stated in this Electronic Credit Payment Form.
- 5 Any use of correction fluid on document(s) required for the purposes of this request for Electronic Credit Payment will not be accepted.
- 6 Lonpac Insurance Bhd ("Company") reserves the right to release claims payment by cheque if the Company finds that any information and/or document(s) provided with this Electronic Credit Payment Form is incomplete, invalid and/or inconsistent.
- 7 Payment by ECP is subject to our final discretion.

CLAIM NO. : _____

POLICY NO. : _____

INSURED : _____

NATURE OF LOSS : _____

DATE OF LOSS : _____

BENEFICIARY NAME : _____
(Bank Account Holder Full Name)

_____ (The Beneficiary Name on the bank account must be stated as above)

NRIC NO./ BUSINESS REGISTRATION NO. : _____
(As stated in bank account)

NAME OF BANK : _____

BANK ACCOUNT NO. : _____

BENEFICIARY ADDRESS : _____

BENEFICIARY EMAIL ADDRESS : _____
(Mandatory for payment notification)

BENEFICIARY TELEPHONE NO. : _____ (Office) _____ (H/P)
(Mandatory for payment notification)

- 1 I confirm that I am the holder of the the bank account specified above ("Account") and that the details thereof are correct, true and complete. I further confirm that I have full power and authority to operate the Account.
- 2 I authorise the Company to deposit claims payments which are payable to me into the Account. I agree that all further claims payment which are payable arising from the same claims event shall be paid into the Account, unless I notify the Company otherwise.
- 3 I acknowledge and agree that the claims payment into the Account shall be a valid discharge of the Company's liability under the Policy. I further agree that the Company shall not be held liable for any damages, losses, claims, costs and/or expenses which I may incur as a result of such payments made into the Account in accordance with my instructions herein.
- 4 I agree to immediately refund to the Company in full any monies paid into the Account which I am not entitled to receive.
- 5 I agree to indemnify the Company for any damages, losses, claims, costs and/or expenses incurred by the Company arising from or in connection with payments made to the Account in accordance with my instructions herein.

Signature of Beneficiary

Company Stamp (if applicable)

Date: