WORKMEN'S COMPENSATION TAKAFUL CLAIM FORM FOR MEDICAL & INJURY CLAIM

IMPORTANT NOTICE TO THE PARTICIPANT

1) The Participant **must provide true and correct information** with respect to the claim made. In the event that false and inaccurate information is provided, Takaful Brunei Am Sdn Bhd ("TBA) reserves its right to repudiate the claim.

2) The Participant must notify this claim and submit this Claim Form **within 14 days** (excluding Sundays and Public Holidays) from the date of incident that gives rise to this claim. TBA reserves the rights to deny this claim upon failure to do so within the specified time limit.

3) The Participant **must complete all relevant sections together with supporting documents** in this Claim Form before submitting to TBA. In the event that this Claim Form is incomplete and not submitted within 14 days from the date of the incident, TBA has the right to deny the claim.

4) The Claim Form must be **signed**, **dated** and **endorsed** with the Participant's **company chop** at every page.

INTERNAL USE ONLY

Date Received:	
Signed:	
Staff ID:	
	☐ Accept ☐ Reject
PLA Number:	
Claim Number:	
Remark:	

CHECKLIST: DOCUMENTS REQUIRED TO BE SUBMITTED

- ☐ Completed Workmen's Compensation Claim Form
- ☐ Copy of Takaful Certificate
- ☐ Copy of IC / Passport of the Employee
- ☐ Copy of Company Registration Form
- ☐ Copy of Borang LD (Borang Permohonan Lesen Pekerja Asing)
- ☐ Copy of Employment Contract
- ☐ Copy of submitted Form A (Labour Department)
- ☐ Copy of submitted SHENA Initial Incident Notification Form
- ☐ Copy of Medical Report / Discharge Ticket
- ☐ Copy of Original Medical Bills
- ☐ Photograph of the Employee's Injuries (Coloured)
- ☐ Copy of the Employee's Salary Slips
- ☐ Copy of Sub-Contractor Agreement *[if any]*
- ☐ Copy of Police Report/Fire Incident Report *[if any]*
- ☐ Copy of Participant's Incident Report *[if any]*
- ☐ Copy of Participant's Bank Statement

Additional Documents Required for Death Claim

- ☐ Copy of Death Certificate
- ☐ Letter of Consent (signed by Participant/Beneficiary)
- ☐ Repatriation Receipt
- ☐ Airway Bill

ACKNOWLEDGMENT/ACCEPTANCE OF THIS CLAIM FORM IS NOT AN ADMISSION OF LIABILITY OR WAIVER ON THE PART OF TAKAFUL BRUNEI AM SDN BHD OF ANY BREACH OF THE TERMS AND CONDITIONS THE PARTICIPANT MAY HAVE BREACHED

IMPORTANT:
PLEASE ENSURE YOU HAVE READ THE NOTICE AT THE FRONT PAGE.
IT IS THE PARTICIPANT'S RESPONSIBILITY TO ENSURE THAT THIS CLAIM FORM IS COMPLETE WITH SUPPORTING DOCUMENTS AND SUBMITTED WITHIN 14 (DAYS) FROM THE DATE OF INCIDENT.
TBA RESERVES ITS RIGHTS UNDER THE RELEVANT CERTIFICATE WORDING AND RELEVANT LAWS.

INITIAL AND COMPANY CHOP:

1. Details of the Participant *[Must be completed by Our Participant]*

Takaful Certificate Number			
Participant's Name *(as per IC)*		**Employer**	
		Main Contractor	
Company Registration Number			
Mailing Address			
Office Telephone Number		**Email Address**	
Facsimile Number			

2. Project Information *[Must be completed by Our Participant]*

Project Title	
Project Location	
Name of Main Contractor	
Name of Sub-Contractor	

3. Details of Focal Person to Contact *[Must be completed by Our Participant]*

Name *(as per IC)*			
IC Number			
Position in the Company			
Office Telephone Number		**Email Address**	
Mobile Number			

4. Details of Employee (Injured/Illness) *[Must be completed by Our Participant]*

Employee Name *(as per IC)*			
IC Number			
Passport Number			
Nationality			
Residential Address			
Residential Telephone Number		**Email Address:**	
Mobile Number			
Date of Employment		**Occupation:**	
Marital Status	*Single* ☐	*Married* ☐	Others (Please Specify):
State Number of Children (below the age of 18) ***[if any]***			

Questionnaire		
Is the Employee in your direct employment?	**Yes** ☐	**No** ☐
If No, please state name and address of the Employer		

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INITIAL AND COMPANY CHOP:

5. Details of Accident/Illness of the Employee *[Must be completed by Our Participant]*

Date		**Time**	
Location of Incident			
Details of Incident			
Nature/Scope of Work of Employee during the Incident			
Questionnaire			
Did the incident happen during working hours?		**Yes** ❑	**No** ❑
Did the Employee consume any medications or alcohol before the incident?		**Yes** ❑	**No** ❑
Was the Employee requested to take any blood, breath or urine test?		**Yes** ❑	**No** ❑
If the incident happened during working hours, please answer the following questionnaire: -			
Was the Employee engaged in the scope of work at the time of the incident?		**Yes** ❑	**No** ❑
Did the incident involve the Employee operating any machineries or equipment?		**Yes** ❑	**No** ❑
If Yes, who provided the Employee with the machinery or equipment?			
Was the Employee provided with any safety gears?		**Yes** ❑	**No** ❑
If Yes, please state who provided the Employee with the machinery or equipment?			
Type of Claim:	❑ Illness - Death	(Please go to Section 6 and 10)	
	❑ Illness	(Please go to Section 7, 9 and 10)	
	❑ Accident	(Please go to Section 8, 9 and 10)	

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INITIAL AND COMPANY CHOP:

6. Details of Death of the Employee due to Illness *[To be completed by Our Participant]*

Date & Time of Death			
Place of Death			
Cause of Death			
Name of Hospital/Clinic		**Date:**	
Questionnaire on Medical Treatment of the Employee [Deceased] (if death due to illness)			
Had the Employee [Deceased] suffered any illness previously?	**Yes ❑**	**No ❑**	
Date of First Consultation of Illness	/ /		
Name of First Hospital/Clinic consulted for this Illness			
Was the Employee [Deceased] admitted and/or warded as an inpatient into the Hospital/Clinic?	**Yes ❑**	**No ❑**	
If Yes, please specify the date(s) of inpatient	/ /	/ /	
Is this Illness a pre-existing condition?	**Yes ❑**	**No ❑**	
If Yes, please specify when and which Hospital/Clinic in which the Employee [Deceased] was first diagnosed of the Illness	/ /		
Does the Participant require immediate repatriation of the Employee [Deceased]?	**Yes ❑**	**No ❑**	

7. Details of Treatment of the Employee due to Illness *[To be completed by Our Participant]*

Name of Diagnosis / Illness			
Symptoms of Diagnosis / Illness			
Date of Confirmed Diagnosis			
Name of Hospital/Clinic		**Date:**	/ /
Type of Treatment/Surgery			
Questionnaire on Medical Treatment of the Employee			
How long had the symptoms existed prior to first treatment?			
Date of First Consultation of Illness	/ /		
Name of First Hospital/Clinic consulted for this Illness			
Was the Employee admitted and/or warded as inpatient into the Hospital/Clinic?	**Yes ❑**	**No ❑**	
If Yes, please specify the date(s) of inpatient	/ /	/ /	
Was the Employee given any a Medical Certificate (MC)?	**Yes ❑**	**No ❑**	
If Yes, please specify the date(s) of Medical Certificate (MC)	/ /	/ /	
Is this Illness a pre-existing condition?	**Yes ❑**	**No ❑**	
If Yes, please specify when the Employee was first diagnosed	/ /		
Is the Illness in relation to pregnancy, miscarriage and/or child birth related?	**Yes ❑**	**No ❑**	
Is the Illness in relation to congenital anomaly (i.e. genetic, hereditary etc.) in nature?	**Yes ❑**	**No ❑**	
If Yes, please specify the congenital anomaly			

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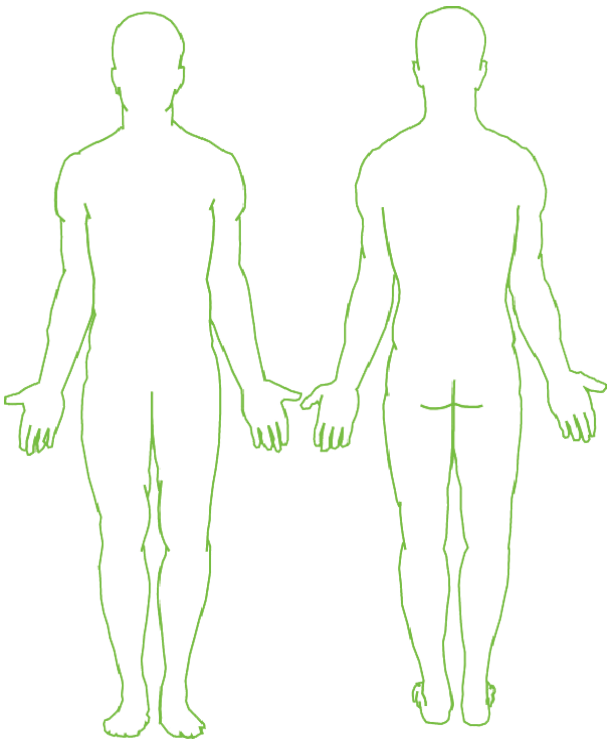
INITIAL AND COMPANY CHOP:

8. Details of Injury of the Employee due to Accident *[To be completed by Our Participant]*

Type of Injury:	❑ Death	❑ Severe Injury	❑ Minor Injury
Details of Injury:			

Location of Injury:
(Please [X] which part of the body was injured in the following diagram)



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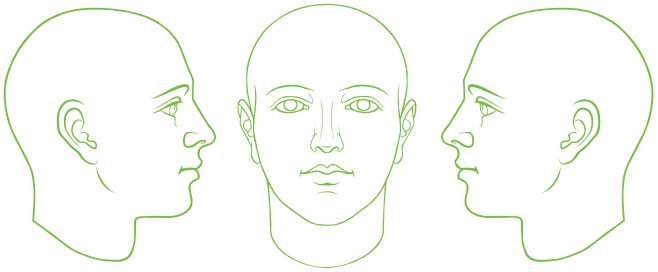

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Name of Hospital/Clinic:		**Date:**	/ /
Type of Treatment/Surgery:			

Questionnaire on Medical Treatment of the Employee		
Was the Employee admitted and/or warded as inpatient into the Hospital/Clinic?	**Yes** ❑	**No** ❑
If Yes, please specify the date(s) of inpatient	/ /	/ /
Was the Employee given any Medical Certificate (MC)?	**Yes** ❑	**No** ❑
If Yes, please specify the date(s) of Medical Certificate	/ /	/ /
Are there any photos of the injuries sustained by the Employee?	**Yes** ❑	**No** ❑
If Yes, please append colour photos together with this Claim Form		
Questionnaire on Reporting of the Incident involving the Employee		
1. Labour Department, Ministry of Home Affairs	**Yes** ❑	**No** ❑
2. Safety, Health & Environment National Authority (SHENA)	**Yes** ❑	**No** ❑
3. Police Department	**Yes** ❑	**No** ❑
4. Other (please state)		
Does the Participant require immediate repatriation of the Employee [Deceased]?	**Yes** ❑	**No** ❑

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INITIAL AND COMPANY CHOP:

9. Current Condition of the Employee *[To be completed by Our Participant]*

Questionnaire		
What is the current Health Condition of the Employee?		
Is the Employee currently working?	**Yes ❑**	**No ❑**
If Yes (currently working), is the Employee doing his/her pre-accident works?	**Yes ❑**	**No ❑**
If No, please specify his/her current work/tasks		
If the Employee is not working, please specify the reason		
Did the Employee suffer from any permanent / temporary loss of disability due to the Accident/Illness? *If Yes, please provide supporting documents	**Yes ❑**	**No ❑**
Is the Employee's salary still the same as his/her pre-accident salary *Please provide salary slips 6 months prior to the accident	**Yes ❑**	**No ❑**
Has the Employee requested to be returned back to his/her home country for further treatment as a result of the Accident/Illness before returning back to work?	**Yes ❑**	**No ❑**
Has the Employee requested the Participant to send him/her back Home to his/her home country as a result of the Accident/Illness? If yes, please provide documentary evidence	**Yes ❑**	**No ❑**
Does the Participant intend to terminate the Employee's contract of employment due to his Accident/Illness?	**Yes ❑**	**No ❑**
Has the Employee been approached by third-party individuals (i.e. Lawyers, Ambulance Chaser) as a result of the Accident?	**Yes ❑**	**No ❑**

10. Bank Details of the Participant *[Must be completed by Our Participant]*

Bank Name	
Bank Account Number	
Bank Account Holder Name	
Company Registration Number	

TAKE NOTICE that any payment shall be made to the bank account details as provided by the Participant and TBA shall bear no responsibility to any error on the part of the Participant.

11. Acknowledgement & Declaration

I/We to the best of my/our knowledge hereby confirm that the statements contained hereinabove are true and correct and I/We have not concealed, misrepresented any material facts in relation to the above claim. If I/We provide any false statement, Takaful Brunei Am Sdn Bhd shall reserve its rights to repudiate the claim.

Should this form be filled by any other party on My/Our behalf, I/We declare that all the statements made by them shall be deemed as Mine/Ours and I/We declare to take full responsibility to the statements made.

I/We further agree to provide full co-operation to Takaful Brunei Am Sdn Bhd or any other party acting for and on behalf of Takaful Brunei Am Sdn Bhd pertaining to the claim.

_____

Participant's Signature

_____

Participant's Name

Date ___ /___ /_____

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