RHB INSURANCE BERHAD (Co. No. 38000-U)
LEVEL 12, WEST WING, THE ICON, NO.1, JALAN 1/68F, JALAN TUN RAZAK, 55000 KUALA LUMPUR
TEL: 03-2180 3000 / 2180 3200 FAX: 03-2161 6322 (Claims)

CLAIM FORM - ☐ RHB CREDIT CARD HOSPITAL CASH PLAN
☐ HOSPITALISATION & SURGICAL MEDICAL BENEFITS

INSTRUCTION
1. This form and Medical Report overleaf must be fully completed to avoid any delay in the settlement of claim.
2. Please furnished a copy of medical bill to expediate settlement of claim.
3. If the patients is a child, the parent/insured should sign the statement of consent. Birth certificate of child must be produced.

SECTION 1 - TO BE COMPLETED BY THE INSURED

1. Policy No. : Period of Insurance :	Claim No. : Insurance Plan of Claimant : Date of Appointment:
2. Name of Insured / Member : Occupation :	Date of Birth : Race : Hospital in Patient Card No. :

SECTION 2 - TO BE COMPLETED IF CLAIM MADE FOR INSURED DEPENDENT

☐ Spouse Name :	Date of Marriage :
☐ Son / Daughter Name :	Date of Birth :

SECTION 3 - ACCIDENT (PLEASE OMIT IF NOT APPLICABLE)

1. Date :	2. Time :
3. Place :	
4. At Work : ☐ Yes ☐ No	
5. State how it happened :	

SECTION 4 - SICKNESS (PLEASE OMIT IF NOT APPLICABLE)

1. Name of Illness :	Date first Discovered :
2. Has this condition been treated previously? ☐ Yes ☐ No	Date first Treated / Consulted :
If "Yes" state name of Doctor, Hospital and Address.	

SECTION 5 - OTHER INFORMATION (TO BE COMPLETED FOR ANY CASES)

1. Name & Address of Hospital / Clinic :	
2. Date Admitted / Treated :	3. Date Discharged, if hospitalised :
4. Date Surgery Performed :	
5. Sick Leave : From to	No. of days : (Please attach medical certificates)

SECTION 6 - ONLY APPLICABLE FOR HOSPITALIZATION & SURGICAL CLAIM

1. Has claim been field for Workmen's Compensation / SOCSO? ☐ Yes ☐ No Will such claim be field? ☐ Yes ☐ No	
2. Claim cheques should be made payable to : ☐ Hospital ☐ Doctor ☐ Employer ☐ Employee	

SECTION 7 - STATEMENT OF CONSENT BY THE PATIENT / PARENT / EMPLOYEE

I hereby authorize any physician, or any hospital who has attended me / my child to furnish or disclose all known facts concerning this disability to RHB Insurance Berhad. A photocopy of this authorisation shall be considered as effective and valid as the original.

Signature of patient / Parent / Employee _____ I/C No. _____ Dated _____

Signature of Insured _____ Dated _____