Liberty Insurance Berhad (16688-K)

8th Floor Menar Liberty, 1008 Jalan Sultan Ismail,50250 Kuala Lumpur, Malaysia.

P.O. Box 6120 Pudu, 59916 Kuala Lumpur.

Tel: 03-2619 9000 Fax: 03-2693 0111 www.libertyinsurance.com.my

NOTICE OF CLAIM UNDER PERSONAL ACCIDENT POLICY

POLICYHOLDER'S PARTICULARS

Name		Policy No	
Address		GST Regn No Date of Regn Purpose of use	Commercial/Personal
Tel No		Email	

CLAIMANT'S PARTICULARS

Name		I/C No	
Address			
Tel No		Email	

PARTICULARS OF ACCIDENT

Date of Accident		Time	
Description of Accident			
Description of Injury			
Was there a previous injury? (Please describe)			
Date resumed work			
Has any claim been made against any other party in respect of this accident?			Yes/No

BANK GIRO DETAILS

To facilitate us with fast claims payment by direct transfer to your bank account, please furnish us with the following bank details.

Name (as per bank account)		Name of Bank	
Account No		Bank Branch	

I/We hereby declare that the above information and document submitted are true and correct and I/we have not withheld from the Company any information of which I/we have knowledge in respect of the above statements.

I/we hereby confirm that I/we have read, understood and agree to be bound by the terms of the Liberty Insurance Berhad Privacy Notice (which is available at www.libertyinsurance.com.my or has been made available to me) and consent to the processing of my Personal data as described in the Liberty Insurance Privacy Notice. In particular, I/We, understand and agree that any Personal Data collected or held by Liberty Insurance Berhad whether contained in this application or otherwise obtained may be held, used, processed and disclosed by Liberty Insurance Berhad to individuals and/or organizations related to and associated with Liberty Insurance Berhad or any selected third party (within or outside Malaysia, including but not limited to medical institutions, reinsurers, claim adjusters/investigators, solicitors, industry associations, regulators, statutory bodies and government authorities as described in the Liberty Insurance Berhad Privacy Notice) for the purpose of processing this application/claim and providing subsequent service related to it and to communicate with me/us for such purposes.

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Signature

Name ______________________

I/C No ______________________

Date ______________________

MEDICAL REPORT

Name of Patient		I/C No	
Date of Injury		Occupation	
Cause of Injury			
Nature of Injury			

Please state treatment administered to the patient	
Please describe if the patient has any other past or present condition that affects this injury?	

In your opinion, please state how long this patient will be unable to perform his duties in respect of his occupation:

Temporary disabled from ____________________ to ____________________

Totally disabled from ____________________ to ____________________

FOR PERMANENT DISABILITY only

Please describe how the injuries affect the permanent physical disability of the patient	
Please state the reason for your opinion that the patient is permanently physically disabled	
Does the patient have any medical/physical condition that caused/contributed to the accident or complicated the treatment/recovery from the injuries	
Is there a possibility that the patient will recover partially/totally from the physical disability with treatment/rehabilitation? Please describe the possible treatment/ rehabilitation	

I hereby authorise the medical establishement or doctor or physician or any other medical personnnel who attended to me to disclose any and all information in respect of my medical condition, not limited to sickness, injury, medical history, consultations, prescriptions and treatment to Liberty Insurance Berhad or its representatives.
I declare that any manner of copy of this authorisation whether in physical or digital form is as effective and valid as the original.

I hereby certify that the above are true and correct and is an accurate account from our medical record.
I declare that I will entertain any and all further enquiries from Liberty Insurance Berhad or its representatives promptly and accurately.

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Signature of Patient
Date ____________________

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Signature of doctor/physician/specialist with stamp
Date ____________________