MPI Generali Insurans Berhad (14730-X)
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Multi Lucky Personal Accident Claim Form

Policy	Policy No.: …… …… Claim No: ……
Personal Accident Benefit	Please tick the type of benefit you are claiming:- ( ) Total Paralysis Care ( ) Hospital Income ( ) Accidental Death ( ) Repatriation Expenses ( ) Permanent Disablement ( ) Kidnap Expenses ( ) Financial Obligations ( ) Personal Liability
Insured Person	Name: …… Age: …… Nationality: …… Address: …… …… Occupation: …… NRIC/Passport No.: …… E-mail address: …… Tel. No.: ……(H)……(H/P) GST Registered: ( ) Yes ( ) No GST Registration No.: ……
Legal Representative (for Fatal case only)	Name: …… NRIC/Passport No.: …… Address: …… …… Relationship with Insured Person: …… Tel. No.: ……(H)……(H/P)
Accident	Day, Date & Time of accident: …… Place of accident: …… Please describe how the accident occurred: …… …… Name of witness: ……Tel No.:……(H)……(H/P)
General Information	Give the name and address of the medical practitioner who is, or has been, attending to you/the injured person for this injury. …… Has he attended to you/the injured person previously for any illness or injury ? ……

I/We hereby warrant that the above statements are true and correct and that I/We have not withheld from the Company any material information in connection with this claim. I/We further authorise the release of further medical information by the doctor should the Company require it. Any photostat copy of this authorisation shall be as effective and valid as the original.

Date: ……

Signature of Insured Person or Legal Representative: ……

Name: ……

NRIC/Passport No: ……

MEDICAL CERTIFICATE

To be completed by the attending medical practitioner

1. Name of patient ……

2. Date Admitted …….. Date Discharged……

3. Profession, business or occupation of the patient ……

4. Region injured (If limb, state whether right or left) ……

5. Nature and extent of injuries (please state in details) ……

……

6. a) State as fully as possible the cause of the Accident ……

   b) Is the appearance of the injury consistent with the accident? ☐ Yes ☐ No
   If no, please give details ……

7. Is there any connection between the present disablement and any disease or previous disability? If yes, please details …… ☐ Yes ☐ No

8. Is surgical interference necessary or likely to become so? ☐ Yes ☐ No
   If yes, please give details ……

9. Is there anything in his/her medical history which may likely to retard his/her recovery? If Yes, please give details …… ☐ Yes ☐ No
   If yes, please give details

10. Have you any reason to suppose that he/she was under the influence of intoxicants at the time of the accident? ☐ Yes ☐ No
    If yes, please give details ……

11. Are the injuries as such will prevent the patient from performing the following without any assistance in the next 12 months:-

    a) Toileting: The ability to use toilet, including getting in and out of it ☐ Yes ☐ No

    b) Mobility: The ability to get in and out of bed and a chair ☐ Yes ☐ No

    c) Continence: The ability to control bowel or bladder functions ☐ Yes ☐ No

    d) Dressing: Putting on and taking off clothing ☐ Yes ☐ No

    e) Bathing/Washing: The ability to take bath or shower (including getting in or out of the bath or shower) or wash by any other means ☐ Yes ☐ No

    f) Feeding: The ability to get food from a plate into the mouth ☐ Yes ☐ No

12. Are you his/her usual medical attendant? If yes, how long have you know him/her and for what other ailment have you treated him/her? ……

13. When did you first see and examine the injured person after the Accident described herein? ……

Signature of doctor …… Name and Qualification of doctor ……

Date: …… Name and Address of Hospital/Clinic/Medical Centre …… . ……

…… … ……

Email address: ……

Documents to be submitted together with this Claim Form:-

For Total Paralysis Care

a) Medical certificate portion of the Claim Form duly completed by the attending medical practitioner

For Death Claim

a) Police Report
b) Death Certificate
c) Burial Certificate
d) Post Mortem Report
e) NRIC or Passport of the Deceased

For Permanent Disablement Claim

a) Medical certificate portion of the Claim Form duly completed by the attending medical practitioner
b) Photographs or x-ray report if there is severance of any part of body

For Hospital Income Claim

a) Medical certificate portion of the Claim Form duly completed by the attending medical practitioner
b) A copy of Inpatient Bill/Admission and Discharge Note

For Repatriation Expenses Claim

a) Invoice or receipt for the expenses incurred in transporting mortal back to home country

For Personal Liability Claim

a) Statement of claim from the third party
b) Other documents to support the claim

Note: The above list of documents may not be exhaustive as additional documents may be required, if necessary, to process the claim.