How to fill in AIG Claim Form

1. Write LEGIBLY with a BLUE or BLACK pen on all MARKED column only in the AIG Claim form.

2. Ensure the form is READABLE and COMPLETED before submitting to ISS office. Failure to complete the form may result in DELAY of getting claim reimbursement.

3. Claim will be reimburse in RINGGIT (MYR) and payment will be banked-in directly (GIRO) to your local bank account. Please ensure that you have an ACTIVE local bank account.

4. All necessary original claim documents are to be submitted within 90 days of the incurred date. Submission after 90 days is subjected to approval by AIG.

Have you enclosed the following documents? Attach the following documents

<table>
<thead>
<tr>
<th>NO</th>
<th>DESCRIPTION</th>
<th>Please tick(\check)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Original official receipt - Receipt <strong>must not be</strong> photocopied nor the word ‘REPRINT’ or ‘DUPLICATE’</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Applicable for Hospital claims<em>Original</em> tax invoice(s),</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>i. Receipt 1 amount: 50</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>ii. Receipt 2 amount: 70</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>iii. Receipt 3 amount:</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>iv. Receipt 4 amount:</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>v. Receipt 5 amount:</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>vi. Receipt 6 amount:</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> MEDICAL REPORT is required by attending doctor IF the sum of all medical bill(s) exceed RM500.00 in total per claim.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Photocopy of passport info page (it must be <strong>same passport</strong> you used to open your bank account.)</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>Photocopy of bank book or bank statement or snapshot of the bank account number under your name</td>
<td>✓</td>
</tr>
</tbody>
</table>

If you have all the relevant documents, please submit to:

INTERNATIONAL STUDENT SUPPORT (ISS), STUDENT EXPERIENCE
Building 2, Level 2, Room 2-2-29
Email: iss.adviser@monash.edu  Emergency Numbers: +603 551 46333 or +6019 272 5859

Edited 18 Nov 2017
PERSONAL ACCIDENT AND HEALTH CLAIM FORM

This form must be completed truthfully and accurately. If the space is not enough or no applicable field available, please supplement information by attachment. The list of documents required is not exhaustive and we reserve the right to request from you any additional information/documentation, as necessary. The submission of an incomplete form or insufficient information or supporting documents may delay the processing or result in the denial of your claim.

The completed form should be returned to us together with all supporting documents as soon as possible at the following address:

AIG Malaysia Insurance Berhad (795492-W)
Claims Department, Level 16
Menara Worldwide, 19B Jalan Bukit Bintang,
55100 Kuala Lumpur, Malaysia
Telephone: 1 800 88 8811
Facsimile: 603 2685 4896
Email address: AIGMYCare@aig.com
www.aig.my

Section I – General Information (REQUIRED)

Name of Insured (as per NRIC / Certificate of Incorporation):

[ ] My Name

[ ] My Passport Number

Name of Claimant (as per NRIC / Certificate of Incorporation):

(Only applicable for total case)

Claimant’s NRIC No./Passport No.:

Relationship between Claimant & Insured:

Name of Parent/Legal Guardian (only applicable if the Insured is below the age of 18):

Parent/Legal Guardian’s NRIC No./Passport No.:

Claimant’s E-Mail Address:

[ ] My Email Address

Claimant’s Mobile Phone No.:

[ ] My Local Number

Insured’s Occupation:

STUDENT

Mailing Address:

[ ] Postal or residential Address

Are you a citizen of the United States?

[ ] Yes

[ ] No

If yes, please provide your social security number:

AIG Malaysia Insurance Berhad (795492-W) is a subsidiary of U.S. company and as such is required to report injury claims of U.S. citizens who may be eligible to receive “Medicare” (pursuant to the Medicare, Medicaid & SCHIP Extension Act of 2007). This information is requested solely to enable us to comply with this reporting requirement.

Claim Type

[ ] New Claim

[ ] Further Claim, with Claim Number: __________________________

Claim Item (please tick):

[ ] Outpatient Medical Expense

[ ] Critical Illness

[ ] Broken Bone

[ ] Weekly Indemnity

[ ] Hospital Income

[ ] Permanent Disability

[ ] Other, please specify:

[ ] Hospital Expenses

[ ] Accidental Death

[ ] Amount RM 120

Do you have any other insurance policies covering this loss or expenses incurred?

[ ] Yes

[ ] No

If yes, please provide the details below

Name of Insurer: __________________________

Policy No.: __________________________ Policy Type: __________________________ Sum Insured: __________________________

Bank Details for E-Payment

Account Holder’s Name (must be the insured or insured’s Parent/ Legal Guardian if the Insured is below the age of 18):

[ ] My Name

[ ] Name of Local Bank

Bank Name: __________________________

[ ] My Email Address

[ ] Bank account number

Notification of payment will be sent to this email address

[ ] My Email Address

[ ] Bank account number
Section II - Details of Injury / Sickness / Incident

Date and time of the injury/sickness/incident: 26/3/2018
Date of first consultation with doctor/hospital: 25/3/2018
Nature of injury/Diagnosis of sickness/incident: Cut

In the case of injury, where and how did the accident occur? In the case of sickness, what were the symptom(s) and when did the symptom(s) first appear?

I fell down the stairs

Part of body affected: Leg
Name of the attending doctor: Dr. XYY
Address of where the patient is treated: Sunmed Clinic

Name of Witness(es) (Applicable to Injury Claim):
Address of witness(es) (Applicable to Injury Claim):
Contact number of witness(es) (Applicable to Injury Claim):

Was the injury due to any other person’s fault?
□ Yes □ No

If yes, please provide name, address and contact number of this third party(s):

Did this accident occur in the course of and/or arising out of employment?
□ Yes □ No

If yes, please state the name of the insurance company for Workmen’s Compensation Insurance and the Policy no.
Period of sick leave granted by attending physician
From DD MM YYYY
To DD MM YYYY

Do you need further medical treatment?
□ Yes □ No

If yes, how long will the further medical treatment last?
Section III – Declaration and Authorization

COMPANY DECLARATION (for Group Policy only)

If we hereby certify that is my/our employee effective from and is currently holding the position of

If no longer under employement, please advise the last date of employment:

Day - Month - Year

SCHOOL / KINDERGARTEN DECLARATION

If we hereby certify that is currently a student of my/our school/kindergarten.

Authorised signature of company/school/kindergarten (Please also affix company/school kindergarten rubber stamp)

Name/Designation

Date Signed Day - Month - Year

DECLARATION AND AUTHORIZATION

I/We do solemnly declare that the foregoing particulars are true and correct in every detail. I/We agree that if I/We have made, or, in any further declaration in respect of the said claim, if I/We shall make any false or fraudulent statements or suppress, omit to disclose, or falsely state any material fact whatsoever, this claim shall be voided and all rights of recovery in connection with this claim shall be forfeited.

I/We hereby authorize any physician, medical practitioner, hospital or clinic by whom or where I/my ward have/has been observed or treated, to give full particulars about my/my ward’s health including my/my ward’s whole medical history in respect of this hospitalization/surgery to AIG Malaysia.

I/We declare and confirm that all information provided are full, complete, true and accurate. I hereby authorize AIG Malaysia to release payment via direct credit or GIRO to the above Bank Account. I further understand that AIG Malaysia relies on the above information and instruction in order to make payment and in the event of any loss arising from this payment, AIG Malaysia is absolved from any or all liability.

My Signature

Signature of Claimant

Signature of Policy Holder/Insured Person and Company

Date Signed Day - Month - Year

For all intents and purposes where there is a conflict or ambiguity as to the meaning in the English provisions or the Bahasa Malaysia provisions, it is hereby agreed that the English version will prevail.
## Section IV - Attending Physician Statement  
(Applicable to Hospital Income, Hospital Expense and Critical Illness Claims Only)

<table>
<thead>
<tr>
<th>Patient's Information</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Age:</td>
<td>NSC No. / Passport No.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient's Medical History</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of injury occurred or symptom(s) first appeared: DD MM YYYY</td>
<td>Date of first consultation with you: DD MM YYYY</td>
<td>Was the patient referred by any other doctor or hospital? YES NO</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of first consultation with referring doctor: DD MM YYYY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To the best of your knowledge, has the patient ever had the same or similar condition(s) or symptom(s)?

- Yes
- No

If yes, please state dates and conditions / symptoms:

Was the condition caused by any underlying disease?

- Yes
- No

If yes, please specify:

Is the diagnosis due to or associated with any of the following?

- Congenital anomalies? YES NO
- Heredity condition? YES NO
- Pregnancy or childbirth? YES NO
- Drugs or alcohol? YES NO
- Refractive error or correction of eyesight? YES NO
- Cosmetic or plastic surgery? YES NO
- Routine medical check-up? YES NO
- Mental or nervous disorders? YES NO

| Name of hospital: | Date of admission: DD MM YYYY | Date of discharge: DD MM YYYY |

| Major complaints of the patient: |

In the case of injury, were the patient's complaints solely caused by this current accident? If not, is there any connection with a previous accident or any other cause? Please specify:

Brief discharge summary (including treatments, investigation procedures, results, and/or any complications and follow-up plan):

If this patient had a surgical procedure, please fill in the boxes below:

Name and nature of the procedure:  
Date of the operation: DD MM YYYY

<table>
<thead>
<tr>
<th>Declaration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hereby certify that the facts given above are true to the best of my knowledge.</td>
</tr>
</tbody>
</table>

Signature and stamp:  
Name of attending physician/specialist:  
Date: DD MM YYYY

Qualifications:  
Telephone no.:  
Hospital:  

4
<table>
<thead>
<tr>
<th>No</th>
<th>Description</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name of Account Holder</td>
<td>Must be the same as per name / company name registered with the bank.</td>
</tr>
<tr>
<td></td>
<td>Name Pemegang Akun</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>NRIC or Passport or Company Registration Number</td>
<td>NRIC (new)</td>
</tr>
<tr>
<td></td>
<td>Nombor Ked Bergelasan atau</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Passport atau Pendataran Syarikat</td>
<td>NRIC (old)</td>
</tr>
<tr>
<td></td>
<td>Passport No.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Business Registration No.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Policy Number</td>
<td>Policy number relating to this payment,</td>
</tr>
<tr>
<td></td>
<td>Nombor Polisi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy number relating to this payment,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nombor polisi berkarsen pembayaran ini.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Telephone Number</td>
<td>Telephone number if contact is required,</td>
</tr>
<tr>
<td></td>
<td>Nombor Telefon</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone number if contact is required,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nombor telefon jika perlu ditarungi.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Bank Account Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nombor Akun Bank</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Bank Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nama Akun Bank</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>E-mail Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alamat E-mail</td>
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<tr>
<td></td>
<td>Our bank will notify account holder once</td>
<td></td>
</tr>
<tr>
<td></td>
<td>each remittance has been made.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bank kami akan menandakan pemrogang akun setelah</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pengiriman wang telah dibuat.</td>
<td></td>
</tr>
</tbody>
</table>

**BENEFITS OF E-PAYMENT:** Faster, Convenient & Secure  
**KELEBIHAN E-PEMBAYARAN:** Lebih Cepat, Mudah & Selamat

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**Signature and/or Company Stamp:**

**Tandatangan dan/atau Cop Syarikat:**

**Nama as per NRIC:**

**Nama Penuh seperti di dalam Kad Bergelasan:**

**My Signature**

**My Name**

**Date:**

26/3/2018