AXA Affin General Insurance Berhad (23820-W)
Ground Floor Wisma Boustead
71 Jalan Raja Chulan 50200 Kuala Lumpur
(603) 2170 8282
(603) 2031 7282
customer.service@axa.com.my
www.axa.com.my

Health Claim Form – Cancer Plan

Policy No.:

You are to disclose to us, fully and faithfully all the facts which you know or ought to know, otherwise the claim submitted hereunder may be declined.

We are committed to protect the personal data submitted by and collected from you. For further details, please refer to our "Data Privacy Notice published in our website.

Instructions
To speed up the process, please (1) Complete this form, (2) Attached relevant supporting documents-completed medical report by treating doctor, certified copy of histopathology report & copy of final bill.

A. DETAILS OF INSURED	
Name of Insured /Policyholder :	
NRIC / Passport No :	Contact No :
Policy No:	Email :

B. INFORMATION ON CANCER/TUMOUR RELATED DISEASE

1. Date you were first diagnosed with Cancer ____ dd ____ mm ______ yy

   Details of doctor first diagnosed the Cancer

   Name: Address :

   Phone No :

2. Describe the symptoms:

3. When did you start experiencing the symptoms? Since ____ dd ____ mm ______ yy

4. Do you have any past history of illness or conditions? ☐ Yes ☐ No

   If Yes, please fill the details of previous hospital/clinic/doctor/specialist that have treated you for this illness or other condition/injury for the past 5 years (please use additional sheets if necessary):

Name of hospital/clinic/doctor/specialist	Address	Phone No

5. Were you referred by any doctor prior to your first visit to the doctor stated in Question 1? ☐ Yes ☐ No
   If Yes, please state the name, address and phone no:

Name and address of hospital	Date of Admission	Date of discharge

6. Have you been told to have symptoms of cancer or have any history of cancer before this event? ☐ Yes ☐ No
   If Yes, please state the type of cancer or symptoms.

Name of cancer / symptom	Duration

C. DETAILS OF OTHER INSURER

Name of company	Policy No	Amount of benefit

D. INSURED'S BEST BANK DETAILS

***Payment advice will be sent to your e mail. Please check if your e mail address is given in Section A**

Name (as per bank acc.):		
Name of Bank :	Bank Account No.:	Bank SWIFT Code: (For foreign account only)

E. CLAIMANT'S DECLARATION

I hereby declare that the above statements and facts are true. I hereby authorize any physician, clinic, hospital, insurance company or any organization, institutions or person to give you full particulars about my/the patient's health policy details, medical history and billing information. I further consent to the disclosure of all such medical information and records by you to any insurers, re-insurers, solicitors, my employer, agents/brokers and other third parties in connection with my insurance claims. A duplicate of this authorization shall be as effective and valid as the original.

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Signature of Insured Person / Claimant :

Name: Date:

F. MEDICAL REPORT (To be completed by the patient's treating physician or surgeon)

Name of patient :

Age :

NRIC/Passport/Birth Certificate No :

Name of hospital :

1. Are you patient's regular medical attendant? ☐ Yes ☐ No

   If Yes, for how long _________________ & date you were first consulted. ____ dd ____ mm ______ yy

2. First symptoms presented :

   i. Duration of first symptom : ____ dd ____ mm ______ yy

   ii. Did the patient suffer from any tumour, malignant or benign, including pre-cancerous conditions? ☐ Yes ☐ No
   If Yes, please state details:

Site and organ involved	Lymph node involved

   iii. Was biopsy done for patient? ☐ Yes ☐ No
   If yes, please provide date and result.

Date	Biopsy result	Other diagnostic/investigation test result
____ dd ____ mm _____yy		
____ dd ____ mm _____yy		
____ dd ____ mm _____yy		

   iv. Diagnosis was first made by :

   v. Date when patient first became aware of this diagnosis : _____ dd _____ mm ______ yy

3. What is the Surgical-Pathological cancer staging for this patient? What was the cancer staging system used?

4. What is tumour grading?

5. Is there any distant metastasis? ☐ Yes ☐ No. What are the body parts involved?

6. If the diagnosis is Leukaemia, is it Chronic Lymphatic Leukaemia? ☐ Yes ☐ No
   If Yes, please confirm the Rai stage.

7. If the diagnosis is skin cancer, is it malignant melanoma? ☐ Yes ☐ No

8. Did the patient suffer from brain tumour? ☐ Yes ☐ No. If yes, please answer below:

Site of brain involved	In pituitary gland		In spinal cord	
	☐ Yes	☐ No	☐ Yes	☐ No

9. Has the patient **previously** suffered from cancer or any related illness including pre-cancerous conditions? ☐ Yes ☐ No
   If Yes, please give dates of consultation and the resulting diagnosis (please use additional sheets if necessary):

10. Is there anything in the patient's personal medical history and family history which would have increased the risk of cancer?
    ☐ Yes ☐ No. If Yes, please advise the details.

11. Other medical conditions on underlying disease present?

Medical condition	Since
	____ dd ____ mm ______ yy
	____ dd ____ mm ______ yy
	____ dd ____ mm ______ yy

12. Is the cancer related to AIDS/HIV? ☐ Yes ☐ No

13. Did the patient consult other doctors for this illness/symptom before coming to see you? ☐ Yes ☐ No
    If Yes, please state the details below (please use additional sheets if necessary):

Name and address of hospital/clinic	Date of Admission/Date of visit	Date of discharge

I hereby certify that the answers above are full, complete and true.

Date:

Signature, name and address of physician: