PACIFIC INSURANCE
A member of The Fairfax Group

International Student Medical Insurance via Education Malaysia Global Services (EMGS)

IMPORTANT NOTES

- Asia Assistance Network Sdn Bhd (AAN) is the third-party administrator of The Pacific Insurance Berhad (Insurer)
- For scheduled appointments, kindly arrange for Letter of Guarantee 1 or 2 day(s) in advance by requesting Hospital to fax Pre-Authorisation Form (PAF) i.e. Hospital Admission Form to AAN
- Claims must be submitted to the Insurer within 30 days from the date of consultation or service
- Any medical expenses exceeding the limit of benefits stated in the Schedule of Benefits will be borne by the student / member
- Chronic Illness such as Diabetes, High Blood Pressure, Asthma, Hepatitis B and C carries, Nerve Disorders or Degenerative Disease, Endometriosis, Transverse Myelitis and conditions arising therefrom or associated therewith is not covered
- Excluded Hospitals (Please refer to the List of Excluded Hospitals)
- Policy Exclusions (Please refer to the List of Exclusions)

MEDICAL CARD

- Facilitate the verification process and does not act as a charge card
- Covers for medical treatment costs within your medical insurance
- Allow "cashless" facility at Panel Private Hospital / GP Clinic
- Applicable for Panel Private Hospital / GP Clinic across Malaysia
- Non-transferable

Panel list is available online via:

https://asia-assistance.com/PDF/WebPanelClinic.pdf

HOW DEDUCTIBLE WORKS?

If you participate in Plan EMGS200 with RM25.00 deductible, how it works?
You are required to pay RM25.00 of the eligible medical expenses incurred for each disability / outpatient visit. Insurer will pay the balance of the eligible expenses after deducting the first RM25.00

Example 1: Hospitalisation expenses
Assumed that the eligible hospitalisation expenses = RM8,500.00
Deductible amount per disability = RM25.00
Amount to be paid by you = RM25.00
Amount to be paid by Insurer = RM8,475.00 (RM8,500.00 – RM25.00)

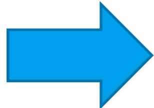
Example 2: Outpatient expenses
Assumed that the eligible outpatient expenses = RM100.00
Deductible amount per outpatient visit = RM25.00
Amount to be paid by you = RM25.00
Amount to be paid by Insurer = RM75.00 (RM100.00 – RM25.00)

INPATIENT PROCESS FLOW

For Hospital Admission
(Pre-planned & Emergency)

ADMISSION & DISCHARGE FLOW

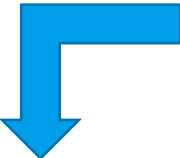
Member



AAN Panel Hospital

- Patient to complete and sign the PAF Part 1
- Attending Physician to complete and sign the PAF. Part 2

- Verify membership validity
- Check on the plan benefits and eligibility

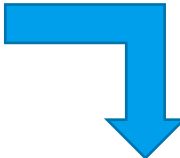


COVERED

- Provide admission guarantee
- Excess deposit may be collected by certain hospitals

DISCHARGE

- Hospital shall fax bills & final diagnosis for assessment
- AAN will issue Final Guarantee Letter & advise excess (if any)
- Hospital will arrange to collect Deductible and excess from the patient



NOT COVERED

- AAN shall inform Insurer & hospital
- Patient to choose to stay or transfer

DISCHARGE

- Patient shall arrange full payment to hospital
- Patient to submit claim for reimbursement consideration

PRE-PLANNED ADMISSION

- Elective surgery / non-emergency
- Complete and sign the PAF
- Hospital to fax PAF to AAN prior to admission date
- To check GL status with AAN call center:
  1. Full name & Passport Number
  2. Hospital Name & Admission Date
  3. Patient’s Contact number

ASIA ASSISTANCE

PRE-AUTHORISATION FORM

Borang Pra-kebenaran

Sign Here & H/P no.

EMERGENCY ADMISSION

- Family member to notify 24hr Alarm Centre
- To provide member's name & Passport number

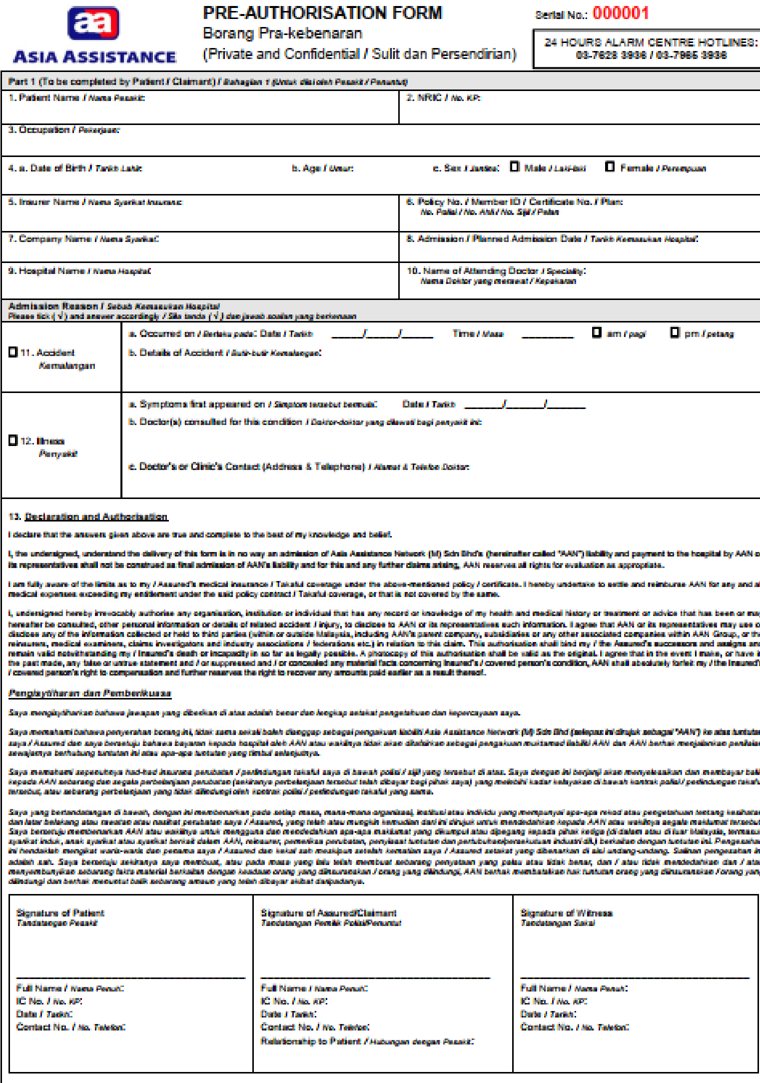
Note:

- Emergency:
  "Condition where as a result of an unforeseen illness or injury, urgent medical treatment is required is order to prevent immediate and/or serious deterioration of an Insured Person's health and the receipt of medical treatment cannot be reasonably delayed"
- To date, the application of this definition is still subjective and we normally place special emphasis on diagnosis like heart related conditions, fracture/accidents, and admissions involving kids to be deemed as emergency.
- In an emergency, the hospital's emergency procedures takes over any other procedures. Patient MUST BE stabilized prior to any financial arrangements.

AT THE ADMISSION COUNTER

- Present Medical Card and Passport
- Patient and Attending Physician to complete & sign the PAF

PRE-AUTHORISATION FORM



ASIA ASSISTANCE

PRE-AUTHORISATION FORM
Borang Pra-kebenaran
(Private and Confidential / Sulit dan Persendirian)

Serial No.: 000001

24 HOURS ALARM CENTRE HOTLINES:
03-7628 3936 / 03-7965 3936

Part 1 (To be completed by Patient / Claimant) / *Bahagian 1 (Untuk diisi oleh Pesakit / Penuntut)*

1. Patient Name / *Nama Pesakit*:	2. NRIC / *No. KP*:
3. Occupation / *Pekerjaan*:	
4. a. Date of Birth / *Tarikh Lahir*: b. Age / *Umur*: c. Sex / *Jantina*: ☐ Male / *Lelaki* ☐ Female / *Perempuan*	
5. Insurer Name / *Nama Syarikat Insurans*:	6. Policy No. / Member ID / Certificate No. / Plan: *No. Polisi / No. Ahli / No. Sijil / Pelan*
7. Company Name / *Nama Syarikat*:	8. Admission / Planned Admission Date / *Tarikh Kemasukan Hospital*:
9. Hospital Name / *Nama Hospital*:	10. Name of Attending Doctor / *Specialty*: *Nama Doktor yang merawat / Kepakaran*

Admission Reason / *Sebab Kemasukan Hospital*
Please tick (√) and answer accordingly / Sila tanda (√) dan jawab soalan yang berkenaan

☐ 11. Accident *Kemalangan*	a. Occurred on / *Berlaku pada*: Date / *Tarikh* ____/____/____ Time / *Masa* ______ ☐ am / *pagi* ☐ pm / *petang* b. Details of Accident / *Butir-butir Kemalangan*:
☐ 12. Illness *Penyakit*	a. Symptoms first appeared on / *Simptom tersebut bermula*: Date / *Tarikh* ____/____/____ b. Doctor(s) consulted for this condition / *Doktor-doktor yang dilawati bagi penyakit ini*: c. Doctor's or Clinic's Contact (Address & Telephone) / *Alamat & Telefon Doktor*:

13. **Declaration and Authorisation**

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I, the undersigned, understand the delivery of this form is in no way an admission of Asia Assistance Network (M) Sdn Bhd's (hereinafter called "AAN") liability and payment to the hospital by AAN or its representatives shall not be construed as final admission of AAN's liability and for this and any further claims arising, AAN reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my / Assured's medical insurance / Takaful coverage under the above-mentioned policy / certificate. I hereby undertake to settle and reimburse AAN for any and all medical expenses exceeding my entitlement under the said policy contract / Takaful coverage, or that is not covered by the same.

I, undersigned hereby irrevocably authorise any organisation, institution or individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident / injury, to disclose to AAN or its representatives such information. I agree that AAN or its representatives may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including AAN's parent company, subsidiaries or any other associated companies within AAN Group, or the reinsurers, medical examiners, claims investigators and industry associations / federations etc.) in relation to this claim. This authorisation shall bind my / the Assured's successors and assigns and remain valid notwithstanding my / Insured's death or incapacity in so far as legally possible. A photocopy of this authorisation shall be valid as the original. I agree that in the event I make, or have in the past made, any false or untrue statement and / or suppressed and / or concealed any material facts concerning Insured's / covered person's condition, AAN shall absolutely forfeit my / the Insured's / covered person's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

Pengisytiharan dan Pemberikuasa

Saya mengisytiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti Asia Assistance Network (M) Sdn Bhd (selepas ini dirujuk sebagai "AAN") ke atas tuntutan saya / Assured dan saya bersetuju bahawa bayaran kepada hospital oleh AAN atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti AAN dan AAN berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had insurans perubatan / perlindungan takaful saya di bawah polisi / sijil yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan dan membayar balik kepada AAN sebarang dan segala perbelanjaan perubatan (sekiranya perbelanjaan tersebut telah dibayar bagi pihak saya) yang melebihi kadar kelayakan di bawah kontrak polisi / perlindungan takaful tersebut, atau sebarang perbelanjaan yang tidak dilindungi oleh kontrak polisi / perlindungan takaful yang sama.

Saya yang bertandatangan di bawah, dengan ini membenarkan pada setiap masa, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengetahuan tentang kesihatan dan latar belakang atau rawatan atau nasihat perubatan saya / Assured, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada AAN atau wakilnya segala maklumat tersebut. Saya bersetuju membenarkan AAN atau wakilnya untuk mengguna dan mendedahkan apa-apa maklumat yang dikumpul atau dipegang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkait dalam AAN, reinsurer, pemeriksa perubatan, penyiasat tuntutan dan pertubuhan/persekutuan industri dll.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikat waris-waris dan penama saya / Assured dan kekal sah meskipun selepas kematian saya / Assured setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat, atau pada masa yang lalu telah membuat sebarang penyataan yang palsu atau tidak benar, dan / atau tidak mendedahkan dan / atau menyembunyikan sebarang fakta material berkaitan dengan keadaan orang yang diinsuranskan / orang yang dilindungi, AAN berhak membatalkan hak tuntutan orang yang diinsuranskan / orang yang dilindungi dan berhak menuntut balik sebarang amaun yang telah dibayar akibat daripadanya.

Signature of Patient *Tandatangan Pesakit*	Signature of Assured/Claimant *Tandatangan Pemilik Polisi/Penuntut*	Signature of Witness *Tandatangan Saksi*
Full Name / *Nama Penuh*: IC No. / *No. KP*: Date / *Tarikh*: Contact No. / *No. Telefon*:	Full Name / *Nama Penuh*: IC No. / *No. KP*: Date / *Tarikh*: Contact No. / *No. Telefon*: Relationship to Patient / *Hubungan dengan Pesakit*:	Full Name / *Nama Penuh*: IC No. / *No. KP*: Date / *Tarikh*: Contact No. / *No. Telefon*:

NOTE: COMPLETION OF THIS PRE-AUTHORISATION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
NOTA: Melengkapkan borang permintaan ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

Asia Assistance Network (M) Sdn Bhd (470560-A), AA One, Block N, Jaya One, 72A, Jalan Universiti, 46200 Petaling Jaya, Selangor D. E., Malaysia FRM_TPA_015A

Part 2 ADMISSION SECTION (To be completed upon admission by Doctor)

1. a. Patient Name: b. NRIC: c. Age: d. Sex: ☐ Male ☐ Female

2. Policy No. / Member ID / Certificate No. / Plan / Company Name:	3. Admission No. / MRN and Hospital Name / Hospital Contact and Fax No.:
4. Admission Date and Time:	5. Expected Days of Stay / Discharge Date:

6. a. Symptoms / Conditions requiring admission:
b. Patient's BP / Temp. / Pulse: d. Date symptoms first appeared: ____/____/____
c. How long is patient aware of the condition: e. Date first consulted: ____/____/____

7. a. Any previous consultation / treatment / hospitalisation for this symptom / illness or related conditions, or other disorders whether in this hospital or any other facilities? ☐ Yes ☐ No
b. Was this patient referred? If yes, please provide details below:
c. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:

Date	Disease / Disorder	Details of Treatment / Hospitalisation	Doctor / Hospital / Clinic

d. Can the condition be managed under the Outpatient basis: ☐ Yes ☐ No
If no, please provide reasons of admission:

8. a. ☐ Admitting Diagnosis: or b. ☐ Provisional Diagnosis:
c. Diagnosis confirmed on ____/____/____ Advised patient on ____/____/____
d. Cause and pathology underlying the present diagnosis:
e. Any possibility of relapse? ☐ Yes ☐ No

9. Estimated Total Costs: RM ________

10. Admission requires: ☐ Hospitalisation ☐ Day Care ☐ On Patient's Request

11. Is the illness / condition related to (please tick (✓) if YES): Please provide details:
- ☐ Pregnancy / Childbirth / Infertility / Caesarean Section / Miscarriage Or any complications arising therefrom.
- ☐ Congenital / Hereditary Diseases
- ☐ Influence of Drugs / Alcohol
- ☐ Nervous / Mental / Emotional / Sleeping Disorder
- ☐ Cosmetic Reason / Dental Care / Refractive Errors Correction
- ☐ AIDS / STD / VD / HIV
- ☐ Self-inflicted Injuries / Violation of Laws / Strike / Riots
- ☐ None of the above

12. Medical treatment, investigation and surgical procedure to be performed, if any (please supply copy of all investigation results):

13. Any other medical / surgical conditions present? ☐ No ☐ Yes, details below:
a. ________ since ____/____/____
b. ________ since ____/____/____

14. Was the patient pregnant at the time of hospitalisation? (For Female Only) ☐ No ☐ Yes, ____ months

15. a. If hospitalisation was due to injury, please describe circumstances and cause of injury:
b. Please indicate date / time of accident: (dd/mm/yy) ____/____/____ (hrs) ______ ☐ am ☐ pm

16. *I hereby certify that I have personally examined and treated the Patient for his / her injury / illness described above and that the facts as stated above represent my medical opinion of his / her condition.*

Date	Name & Signature of Attending Doctor DR's Contact No. and Email Address:	Doctor / Hospital Stamp

Part 3 DISCHARGE SECTION (To be completed upon discharge by Doctor)

17. Undertaking Letter Ref. No. (if available):	18. Date of Discharge:
19. a. Final Diagnosis: ICD code:	b. Cause and pathology of the diagnosis:

20. Treatment given / Investigation done (please supply copy of all investigation results):

21. a. Surgical procedures performed: b. Date of Surgery / Procedure:
MMA code / PHFSR code:

22. a. Recovery complication that arose (if any):
b. In the case of DEATH, please advise Date / Time and Cause of death:

23. *I hereby certify that I have personally examined and treated the Patient for his / her injury / illness described above and that the facts as stated above represent my medical opinion of his / her condition.*

Date	Name & Signature of Attending Doctor DR's Contact No. and Email Address:	Doctor / Hospital Stamp

Asia Assistance Network (M) Sdn Bhd (470560-A), AA One, Block N, Jaya One, 72A, Jalan Universiti, 46200 Petaling Jaya, Selangor D. E., Malaysia FRM_TPA_015A

INITIAL GUARANTEE LETTER

AVISENA SPECIALIST HOSPITAL Fax Number:0355151815

ATTN:ADMISSION
C.C:

Dear ADMISSION,

RE: HOSPITAL ADMISSION GUARANTEE FOR :

PATIENT'S NAME
CLIENT
COMPANY NAME
POLICY NO.
DATE OF ADMISSION

This is to confirm that we provide the ADMISSION GUARANTEE for the above-mentioned patient to your hospital / medical centre of **RM 1000.00 (RINGGIT ONE THOUSAND ONLY)**

Entitlement for ROOM & BOARD : Up to RM 400.00per night

(Includes Room Charge & Meals) 20% Co-Payment Applies

This cover is subjected to the Terms and Conditions of the patient's Insurance policy. Patient shall bear all cost incurred for bills which are not covered under the Insurance policy. Items of a personal nature such as telephone calls, newspaper, television, etc. are excluded. All charges should **NOT** exceed the fees stated in 13th Schedule of PHA. This guarantee also shall exclude any treatment for: N/A

This guarantee is to facilitate admission only. Our admission guarantee stands provided we receive the complete documents upon discharge. Kindly fax to **03-7964 4866** in order for us to the issuance of final guarantee:

1) ITEMISED MEDICAL BILL
2) AA HOSPITAL FORM
3) ALL MEDICAL INVESTIGATION REPORTS

Kindly send the original copies of the above to our address as stated below:
ASIA ASSISTANCE NETWORK (M) SDN. BHD.
LEVEL G, AA ONE, NO 1, BLOCK N, JAYA ONE, 72A, JALAN UNIVERSITI,
46200 PETALING JAYA, SELANGOR DARUL EHSAN, MALAYSIA

NON-GUARANTEE LETTER

To :

ATTN : ADMISSION

C.C. : DARUL MAKMUR MEDICAL CENTRE

From

Fax Number : 095349966

Date : 04/12/2019

File Number : 417193

Dear Sir / Madam,

Insurer

Name of Patient

Policy Number

NRIC

Date of Admission

Weare sorry that we are unable to issue you a letter of guarantee for your hospitalization as your medical condition/treatment does not fall within our authority. We have informed your insurer of your hospitalization and this "non guarantee" status.

In view of the above, we would appreciate if you could arrange to settle all charges with the hospital directly and arrange to submit the following documents to your insurance company for a possible reimbursement:-

1. **Original Invoice/Bill**
2. **Original Receipt**
3. **Medical Report**
4. **All Investigative Reports (If available)**
5. **Referral Letter (If available)**

It is important to note that the issuance of this "Non-Guarantee" does not constitute the denial of claims liability on the part of the Insurer. Please note that this is without prejudice to any other circumstances that may render this claim not payable.

Again, we apologize for this inconvenience and thank you for giving us the opportunity to serve you.

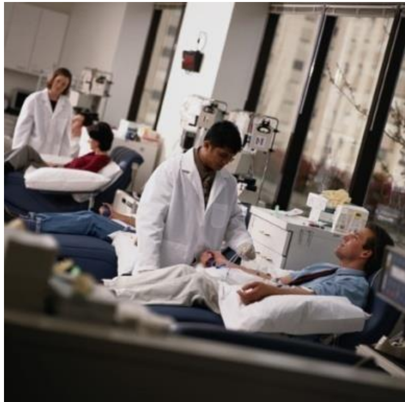
NON-PANEL ADMISSION / PAY & FILE (REIMBURSEMENT)

- Duly completed Insurer Claim Form
- Medical Report / Sijil Discaj
- Original and Itemised Bills
- Original Receipt
- Referral Letter (if available)

NOTE: PAY & SUBMIT TO INSURER FOR POSSIBLE CLAIM

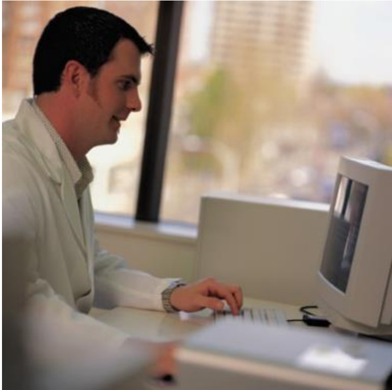
DISCHARGE SCENARIOS

Doctor to advise discharge

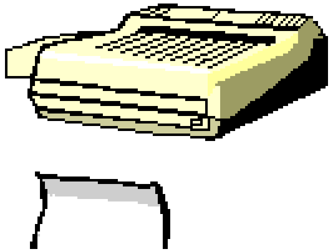


Doctor continues ward visits

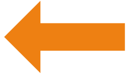
Doctor confirms final diagnosis. Patient discharge procedure begins



Compilation of all medical expenses incurred from different departments



Hospital fax final bill to AAN

 Approximately 2 – 3 hrs

1 hour

FINAL GUARANTEE LETTER

12/06/2019
AVISENA SPECIALIST HOSPITAL

Fax Number:0355151815

ATTN:BILLING
C.C:

Dear BILLING,

RE: HOSPITAL BILL

PATIENT'S NAME
CLIENT
COMPANY NAME
POLICY NO.
DATE OF ADMISSI

Company (M) Bhd

This is to confirm that we are providing the MEDICAL EXPENSES GUARANTEE for the above-mentioned patient to your hospital / medical centre up to **RM 8714.80 (RINGGIT EIGHT THOUSAND SEVEN HUNDRED FOURTEEN AND EIGHTY CENTS ONLY).** This LG will supersede any LG previously issued for this admission.

Entitlement for ROOM & BOARD : Up to RM400.00 per night

(Includes Room Charge & Meals) 20% Co-Payment Applies

This cover is subjected to the Term and Conditions of the patient's Insurance policy. Patient shall bear all cost incurred for bills which are not covered under the Insurance policy. Please refer to Discharge Notice (Patient"s Copy) for excess amount to be paid by the Patient

NOTE: No charges should exceed the fees schedule stipulated in the Thirteenth Schedule of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 (hereinafter referred to as the "Thirteenth Schedule"). Asia Assistance Network (M) Sdn Bhd reserves the right to revise this Medical Expenses Guarantee if found that the charges stipulated in the Patient's medical bills exceeds the maximum amount chargeable as specified by the Thirteenth Schedule. **Please refer to the Discharge Notice (Hospital's Copy) for charges that have exceeded the chargeable amount pursuant to the Thirteenth Schedule.**

Kindly send the original copies of the Medical Bills, AA Hospital Form and Discharge Form to our address as stated below invoices and statements to the address as stated below:

DISCHARGE NOTICE (PATIENT'S COPY)

Insured:		**Insurer:**	
Patient:		**Policy No.:**	
Hospital:	**KPJ SELANGOR SPECIALIST HOSPITAL**	**Admission Date:02/01/2020**	**Discharge Date:04/01/2020**
Total Hospital Charge	**RM 11696.65**		
Total Guaranteed Amount	**RM 10890.40**		

Total Excess by Patient	1	All type of ADMISSION FEES	RM 60.00
	2		
	2		
	3		

EXAMPLE OF NON-COVERED ITEMS

- Admission kit
- Excess of Room & Board
- Telephone cost
- Magazine / Newspaper
- Extra Meals
- Non-medical items
- Excess of policy limit
- Deductible

REIMBURSEMENT PROCESS FLOW

INPATIENT

REIMBURSEMENT DOCUMENTS

Type of Documents	Inpatient (Inclusive of pre/post follow up treatment)
Claim form **(Discharge Medical Report Claims Form(Section I – to be completed by Insured/Claimant, Section II-to be completed by the Attending Doctor)**	Inpatient claim form
Original Tax Invoice • **Itemized bills** • **Detail breakdown**	 √ √
Original Receipt	√
Medical report / Sijil Discaj	√
Bank Account information • **E-payment Authorisation form**	√
Other supporting document as per stipulated at policy level (E.g: Referral letter from the General Practitioner (GP), (if any), Police report if involves in accident.	As per advised by insurer

INPATIENT – PRE/POST DOCUMENT

The Pacific Insurance Berhad

DISCHARGE MEDICAL REPORT CLAIMS

SECTION I - To be completed by the Insured / Claimant (IN BLOCK LETTERS)
SEKSYEN I - Untuk diisi oleh Pihak Diinsuranskan/Pihak Menuntut (DALAM HURUF BESAR)

Name of Insured / *Nama Pihak Diinsuranskan*	NRIC No. / *No. K/P*	Policy No. / *No. Polisi*

Claimant (other than the Insured) / *Pihak Menuntut (selain daripada Pihak Diinsuranskan)*	Claimant is : / *Pihak Menuntut ialah :* ☐ Self/Diri Sendiri ☐ Spouse/Pasangan ☐ Child/Anak	NRIC No. (if applicable) / *No. K/P (jika diterima pakai)*

Birth Date / *Tarikh Lahir* ☐ (dd) Tarikh ☐ (mm) Bulan ☐ (yy) Tahun	Age / *Umur*	Sex / *Jantina* ☐ Male/Lelaki ☐ Female/Perempuan	Race / *Bangsa*

Religion / *Agama*	Marital Status / *Status Perkahwinan*	Occupation / *Pekerjaan*
Employer / *Majikan* Tel. No./*No. Tel.*	Date of Employment / *Tarikh Mula Bekerja*	Employer's Address / *Alamat Majikan*

Type of Claim / *Jenis Tuntutan*
☐ Hospitalisation/*Dimasukkan ke hospital* ☐ Outpatient/*Pesakit Luar* ☐ Accident/*Kemalangan*
Circumstances of Accident/*Keadaan Kemalangan*

Details of other insurance policies, Socso, Workmen's Compensation and others :
Butir-butir insuran lain, Perkeso, Insuran Pampasan Pekerja dan lain-lain :

Policy Type / *Jenis Polisi*	Insurance Company / *Syarikat Insuran*	Policy No. / *No. Polisi*

AUTHORISATION TO PHYSICIAN, HOSPITAL, CLINIC OR INSURANCE COMPANY TO RELEASE INFORMATION
MEMBERI KEBENARAN KEPADA DOKTOR PERUBATAN, HOSPITAL, KLINIK ATAU SYARIKAT INSURAN UNTUK MEMBERI MAKLUMAT

I hereby authorise any physician, medical practitioner, hospital, clinic or insurance company by whom or where I have/my ward has been observed or treated, to give full particulars about my/ward's health including my/ward's whole medical history in respect of this hospitalisation/surgery, to the above insurance company.

Saya dengan ini memberi kebenaran kepada doktor perubatan, pengamal perubatan, hospital, klinik atau syarikat insuran yang merawat saya/tanggungan saya untuk memberi maklumat lengkap berhubung dengan riwayat kesihatan saya/tanggungan saya termasuk latar belakang penuh perubatan saya/tanggungan saya semasa dimasukkan di hospital/menjalani pembedahan kepada syarikat insuran.

Signature of Patient / *Tandatangan Pesakit*	Signature of Insured/Claimant / *Tandatangan Pihak Diinsuranskan/Pihak Menuntut* (Co. Stamp where applicable/*Cop syarikat dimana perlu*)	Date / *Tarikh*

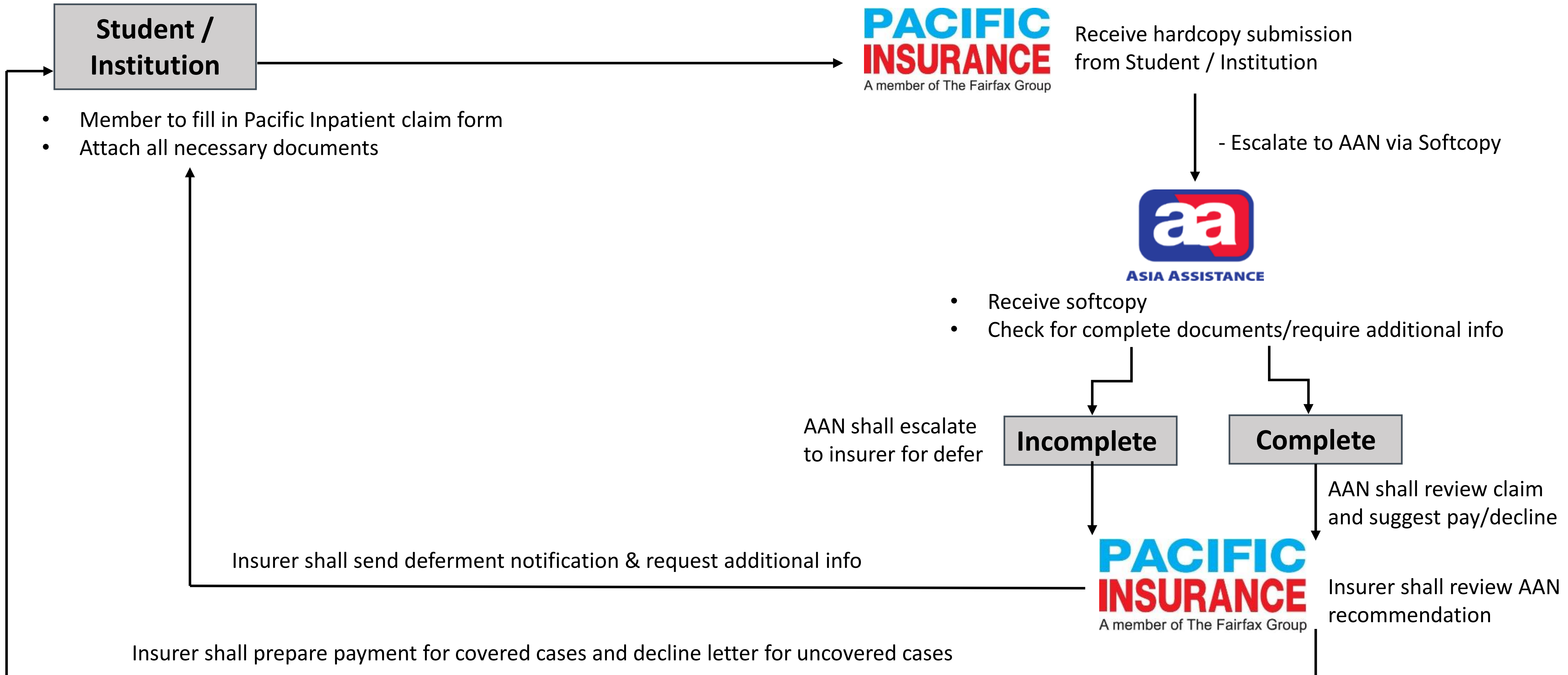
Personal Data Protection Act 2010 ("PDPA") Notification to customers of The Pacific Insurance Berhad ("TPIB")
Under the PDPA, there are various requirements that regulate the processing of your personal data. Please refer to www.pacificinsurance.com.my for details of TPIB PDPA privacy notice.

Akta Perlindungan Data Peribadi 2010 ("APDP") Pemberitahuan kepada pelanggan The Pacific Insurance Berhad ("TPIB")
Dibawah APDP, terdapat pelbagai syarat yang mengawal pemprosesan data peribadi. Sila rujuk di www.pacificinsurance.com.my untuk maklumat terperinci notis privasi TPIB APDP.

Page 1 of 3

- ➢ **SECTION I**
- ➢ **E-Payment Authorization Form**

INPATIENT REIMBURSEMENT PROCESS FLOW

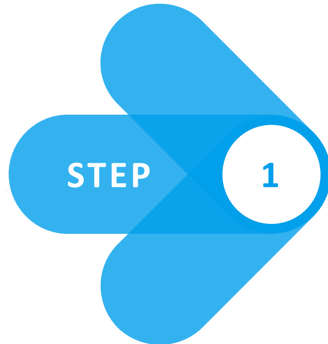


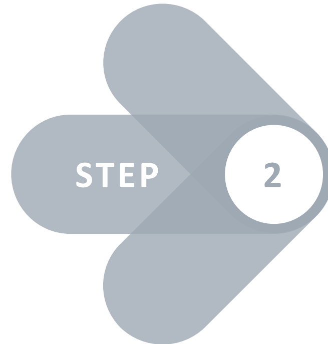
OUTPATIENT PROCESS FLOW

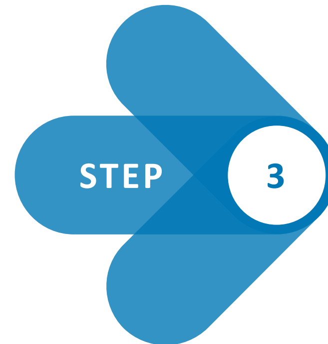
For GP Visitation

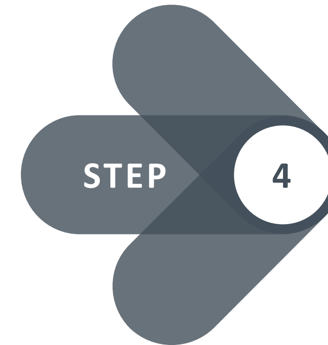
OUTPATIENT

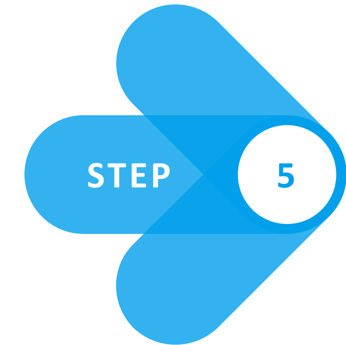
Visiting Panel General Practitioner Clinic (GP)











MEMBER
Member to present Medical Card and Passport to the panel clinic.

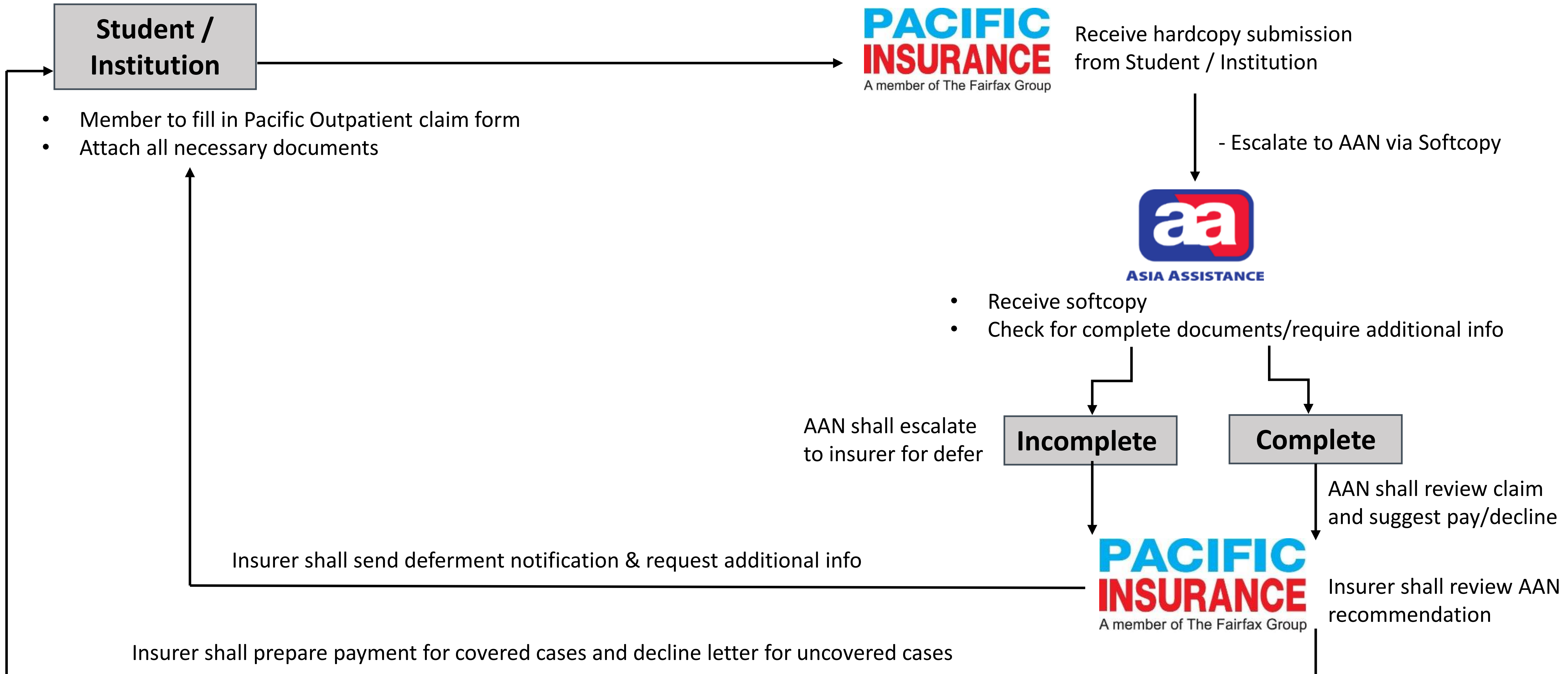
PANEL GP CLINIC
Clinic to verify/validate member details via online portal.

MEDICLINIC
Fill in and sign the AAN MediClinic form.

TREATMENT
Member receives treatment & medication.

BILLING
Clinic will compile and send the bills to MediClinic. Member to pay for Deductible and excess (if any) subject to benefits limit and policy conditions

OUTPATIENT REIMBURSEMENT PROCESS FLOW



OUTPATIENT CLAIM FORM (GP) - Non-Panel Visits Document

The Pacific Insurance Berhad (91603-K)
太平保險有限公司
40-01, Q Sentral, 2A Jalan Stesen Sentral 2,
Kuala Lumpur Sentral, 50470 Kuala Lumpur, Malaysia.
(P.O. Box 12490, 50780 Kuala Lumpur, Malaysia.)
Tel: +603-2630 8999 Fax: +603-2630 8998
Website: www.pacificinsurance.com.my

NOTIFICATION OF OUT-PATIENT CLAIM

A. PARTICULARS OF CLAIMANT

Patient's Name: ______________________ Sex/Age: ____________

Policyholder: ______________________ Policy No.: ____________

Insured's Name if Patient is a dependant: ______________________

B. AUTHORISATION TO RELEASE INFORMATION. I hereby authorize any hospital, clinic or physician to release any information acquired in the course of my examination or treatment.

______________ Date

______________ Signed (Patient; or Parent if a minor)

C. ATTENDING PHYSICIAN'S REPORT:

Diagnosis of Condition(s): ______________________ (Please Print)

Date of Consultation: ______________

______________ Signature of Attending Physician

NOTE: Please attach the original medical bills or receipts together with this form and send them to the Medical Insurance Department of The Pacific Insurance Berhad.

Personal Data Protection Act 2010 ("PDPA") to customers of The Pacific Insurance Berhad ("TPIB")
Under the PDPA, there are various requirements that regulate the processing of your personal data.
Please refer to www.pacificinsurance.com.my for details of TPIB PDPA privacy notice.

NOC 14122015

- Outpatient Claim Form
- E-Payment Authorization Form
- Ideally to have the outpatient claim form completed.
- Alternatively, to have the treating doctor write the diagnosis , sign and rubber stamp on the receipt (for outpatient clinical claims
- During claim submission, Insured required to complete Section A & B

CONTACT LIST

- **24 Hours Alarm Centre (for Hospitalisation Services):**

  +603-7628 3992 or +603-7965 3992

- **24 Hours Mediclinic (for Clinical Services):**

  +603-7628 3966 or +603-7965 3966

- **24 Hours Emergency Medical (for Evacuation / Repatriation Outside Malaysia):**

  +603-7628 3939 or +603-7952 0175

THANK YOU