



# LIABILITY CLAIM FORM

TIMB CLAIM NO:

- The issue of this form is not to be construed as an admission of liability on the part of the Company.
- Each question must be answered fully and completely. If insufficient space is provided for your answers, please continue on a separate sheet.

### DOCUMENTATION CHECKLIST (where appropriate)

<input type="checkbox"/> Copy of duly completed, signed and witnessed claim form  <input type="checkbox"/> Copies of Pay Slips, including allowances payable if any.  <input type="checkbox"/> Copies of letter from injured or injured's legal representative or family members if any  <input type="checkbox"/> Copy of employment letter or last promotion / redesignation letter	<input type="checkbox"/> Invoices, repair quotations, etc. for third party property damaged  <input type="checkbox"/> Copy of Police Report / Medical Report / Death Certificate / postmortem report  <input type="checkbox"/> Copies of all correspondence between your legal firm and the Labour/SOCSO office, if any.  <input type="checkbox"/> Relevant Photographs
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### PARTICULARS OF INSURANCE

Policy No :	Policy Period: From	To
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### INSURED'S PARTICULARS

Name	
Address	
Business / Occupation	Tel. No & Contact Person:

### CIRCUMSTANCES OF LOSS / DAMAGE

Loss Date & Time :	When was loss notified to you?
Address of premises where loss or damage occurred	
State use of premises at time of loss	
Please state details of accident and how the loss / event occurred? (to the best of your knowledge)	
Have you received notification from any third party? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please give details and submit all notices to TIMB - <b>you are reminded that no negotiation, admission or repudiation of any claim may be entered into without TIMB's prior written consent:</b>	
Are there any witnesses to the occurrence of the Loss? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, please provide Names and Addresses / Contact Numbers	
Is the loss for which you are making a claim insured with any other Insurer?	
If yes, please Give the Name of Insurer and policy number	
Who discovered / witnessed the loss or damage? (Please provide Names and Addresses / Tel: No.	



**WITNESS**

Name	Address	Telephone Number
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**WORKMEN'S COMPENSATION / EMPLOYER'S LIABILITY**

Was the injured engaged in the stated occupation at the time of accident?  YES  NO

If no, please state nature of work being done

Is the injured a direct employee?  YES  NO      When did the injured enter your service?

Did the injured suffer from any physical defect prior to the accident?  YES  NO

If yes, please provide details.

State name of Hospital injured was taken Date:

In-patient or Out-patient treatment?  In-patient  Out-patient

Has the Injured been discharged?  YES  NO      If Yes please state date :

Has the Injured returned to work?  YES  NO      If yes,  PARTIALLY  FULLY

Has a report been made to the Labour Office?  YES  NO      SOCSO Office?  YES  NO

Was the injured guilty of any misconduct or disobedience or under influence of drugs / alcohol at the time of accident? Please provide details.

**LIST OF INJURED EMPLOYEES (please use a separate sheet if necessary)**

No	Name	Address	Age	Sex	Marital Status	Nationality	Tel. No (H)	Occupation



**GST DETAILS**

Are you or will you be a registered person under the Malaysian Goods and Services Tax (GST) at the commencement date of this policy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I yes, please provide the following:-		
(i) GST Identification No	:	_____
(ii) Date of registration	:	_____
Is the above policy for:-		
(i) Personal (including sole proprietorship)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
(ii) Business	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is the input tax incurred by you on the medical or personal accident policy premium blocked from claims under Regulation 36 of the GST Regulations 2014? (Applicable for Medical and Personal Accident only)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

I/we acknowledge that I/we have accessed and/or read the Privacy Notice of TIMB (available at all TIMB branch customer service counters and/or TIMB website) and agree to the processing of my/our personal data in the manner specified therein. I/we also consent to the collection, further processing and disclosure of my/our sensitive details herein for the purpose of processing claims and making the related payments.

**DECLARATION**

I/We hereby declare that the above statements and particulars are correct and complete in every respect and I/We have not concealed, misrepresented or misstated any material fact.

I/We agree that if such statements and particulars are written by any other person, such person shall be deemed to have my/our Agent for the purpose of filling in this form and his statement shall be binding upon me/us

I/We hereby acknowledge and understood the contents of the Personal Data Protection Act 2010 and agree to give my fullest co-operation to Tune Insurance Malaysia Berhad or its representative in relation to this claim

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**Name** ..... **Signature**

**Date:** ..... / ..... / .....