BERJAYA SOMPO INSURANCE

REIMBURSEMENT CLAIMS PROCEDURE

Private and Confidential

Below situations will need to submit claims for reimbursement:

BERJAYA SOMPO INSURANCE

1. Visit to non Panel Hospital
2. Pre Hospitalization Diagnostics test
3. Pre Hospitalization Specialist Consultation
4. Post Hospitalization follow up
5. Second Surgical Opinion
6. Emergency Accidental Outpatient Treatment
7. Emergency Accidental Dental Treatment
8. Emergency Sickness Treatment
9. Annual Out-patient Cancer Treatment
10. Annual Out-patient Kidney Dialysis Treatment
11. Daily Cash Allowance
12. Medical Report
13. Funeral Expenses
14. Compassionate Visitation Expenses
15. Tuition Fees, replacement of missed subjects (max per semester) – For student only
16. Clinical claims exceeded amount of RM300 per visit

REIMBURSEMENT CLAIM PROCEDURE

BERJAYA SOMPO INSURANCE

Submit the **ORIGINAL** copy of: Original Bill, Itemised Bill & Receipts, Completed Claim Form, Medical Report and diagnostic report (if any).

↓

Submit all the required claim documents to Berjaya Sompo Insurance for processing.

↓

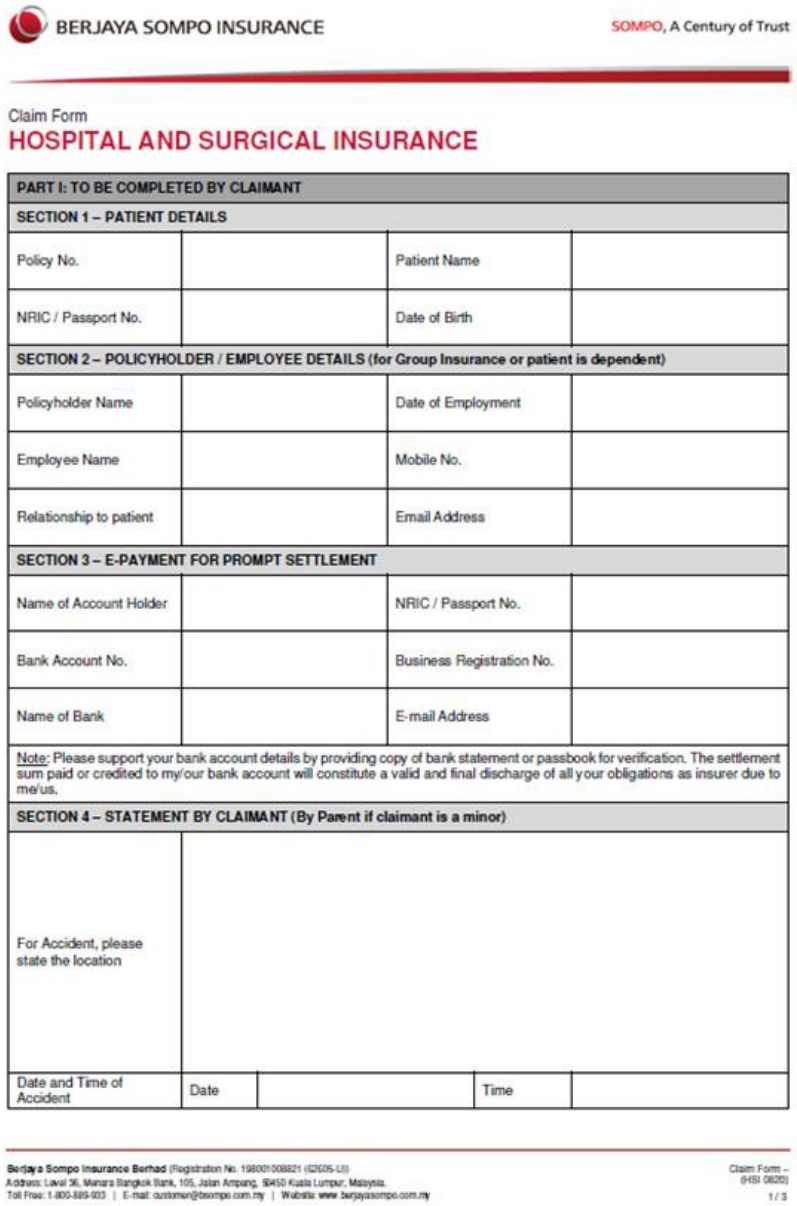
Payment will be credited to member's bank account within 14 Working Days upon receiving completed claim documents and approval of claims.

Remarks*: Send the claim notification with full set of claim documents to ***ebusm@bsompo.com.my before send out the hardcopy documents.

HOW TO COMPLETE THE GHS CLAIM FORM

HOW TO COMPLETE THE CLAIM FORM

BERJAYA SOMPO INSURANCE



BERJAYA SOMPO INSURANCE

SOMPO, A Century of Trust

Claim Form

HOSPITAL AND SURGICAL INSURANCE

PART I: TO BE COMPLETED BY CLAIMANT			
SECTION 1 – PATIENT DETAILS			
Policy No.		Patient Name	
NRIC / Passport No.		Date of Birth	
SECTION 2 – POLICYHOLDER / EMPLOYEE DETAILS (for Group Insurance or patient is dependent)			
Policyholder Name		Date of Employment	
Employee Name		Mobile No.	
Relationship to patient		Email Address	
SECTION 3 – E-PAYMENT FOR PROMPT SETTLEMENT			
Name of Account Holder		NRIC / Passport No.	
Bank Account No.		Business Registration No.	
Name of Bank		E-mail Address	
Note: Please support your bank account details by providing copy of bank statement or passbook for verification. The settlement sum paid or credited to my/our bank account will constitute a valid and final discharge of all your obligations as insurer due to me/us.			
SECTION 4 – STATEMENT BY CLAIMANT (By Parent if claimant is a minor)			
For Accident, please state the location			
Date and Time of Accident	Date		Time

Berjaya Sompo Insurance Berhad (Registration No. 198001008821 (62605-U))
Address: Level 36, Menara Bangkok Bank, 105, Jalan Ampang, 50450 Kuala Lumpur, Malaysia.
Toll Free: 1-800-889-933 | E-mail: customer@bsompo.com.my | Website: www.berjayasompo.com.my

Claim Form – (HSI 0820)
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PART I: To be Completed by Student

Section 1. Particulars of claimant

- Provide claimant details, e.g. full name, passport no. etc

Section 2. Policyholder/Employee Details

- Further details on the student/ dependent

Section 3. E-Payment

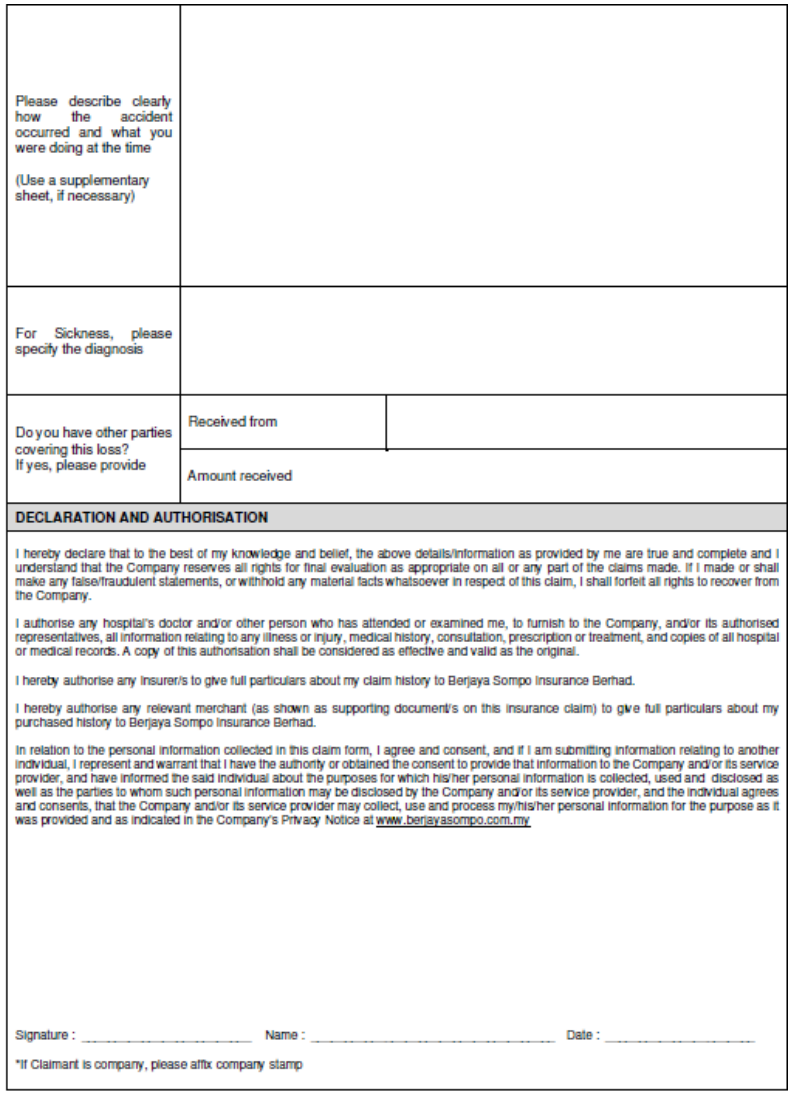
- Provide Malaysia bank account details

Section 4. Statement by Claimant

- Further explanation on the accident/ sickness

HOW TO COMPLETE THE CLAIM FORM

BERJAYA SOMPO INSURANCE



Please describe clearly how the accident occurred and what you were doing at the time (Use a supplementary sheet, if necessary)		
For Sickness, please specify the diagnosis		
Do you have other parties covering this loss? If yes, please provide	Received from	
	Amount received	

DECLARATION AND AUTHORISATION

I hereby declare that to the best of my knowledge and belief, the above details/information as provided by me are true and complete and I understand that the Company reserves all rights for final evaluation as appropriate on all or any part of the claims made. If I made or shall make any false/fraudulent statements, or withhold any material facts whatsoever in respect of this claim, I shall forfeit all rights to recover from the Company.

I authorise any hospital's doctor and/or other person who has attended or examined me, to furnish to the Company, and/or its authorised representatives, all information relating to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

I hereby authorise any insurer/s to give full particulars about my claim history to Berjaya Sompo Insurance Berhad.

I hereby authorise any relevant merchant (as shown as supporting document/s on this insurance claim) to give full particulars about my purchased history to Berjaya Sompo Insurance Berhad.

In relation to the personal information collected in this claim form, I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority or obtained the consent to provide that information to the Company and/or its service provider, and have informed the said individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the Company and/or its service provider, and the individual agrees and consents, that the Company and/or its service provider may collect, use and process my/his/her personal information for the purpose as it was provided and as indicated in the Company's Privacy Notice at www.berjayasompo.com.my

Signature : _____ Name : _____ Date : _____

*If Claimant is company, please affix company stamp

Berjaya Sompo Insurance Berhad (Registration No. 198001006821 (52605-U))
Address: Level 36, Menara Bangkok Bank, 105, Jalan Ampang, 50450 Kuala Lumpur, Malaysia.
Toll Free: 1-800-889-933 | E-mail: customer@bsompo.com.my | Website: www.berjayasompo.com.my

Claim Form – (HSI 0820)
2 / 3

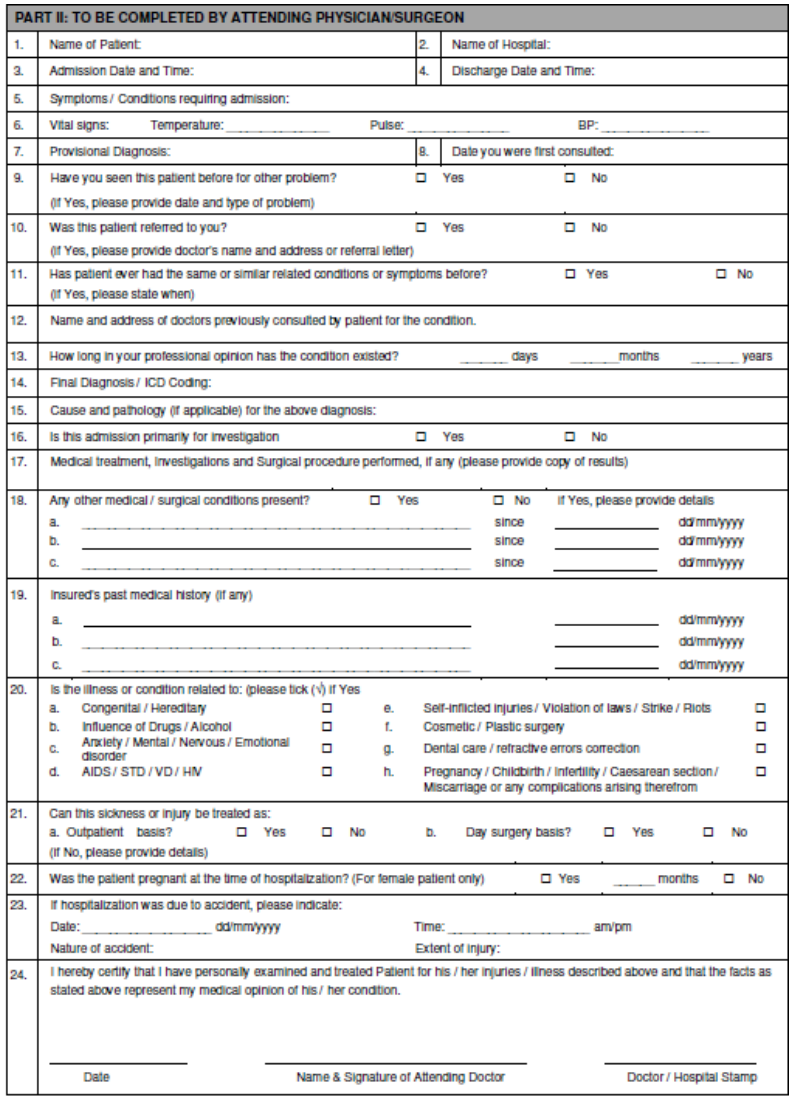
PART I: To be Completed by Student

Declaration and Authorization

- Signature, name and passport no. of the claimants

HOW TO COMPLETE THE CLAIM FORM

BERJAYA SOMPO INSURANCE



PART II: TO BE COMPLETED BY ATTENDING PHYSICIAN/SURGEON

1.	Name of Patient:	2.	Name of Hospital:
3.	Admission Date and Time:	4.	Discharge Date and Time:
5.	Symptoms / Conditions requiring admission:		
6.	Vital signs: Temperature:_____ Pulse:_____ BP:_____		
7.	Provisional Diagnosis:	8.	Date you were first consulted:
9.	Have you seen this patient before for other problem? ☐ Yes ☐ No (If Yes, please provide date and type of problem)		
10.	Was this patient referred to you? ☐ Yes ☐ No (If Yes, please provide doctor's name and address or referral letter)		
11.	Has patient ever had the same or similar related conditions or symptoms before? ☐ Yes ☐ No (If Yes, please state when)		
12.	Name and address of doctors previously consulted by patient for the condition.		
13.	How long in your professional opinion has the condition existed? _____ days _____ months _____ years		
14.	Final Diagnosis / ICD Coding:		
15.	Cause and pathology (if applicable) for the above diagnosis:		
16.	Is this admission primarily for investigation ☐ Yes ☐ No		
17.	Medical treatment, investigations and Surgical procedure performed, if any (please provide copy of results)		
18.	Any other medical / surgical conditions present? ☐ Yes ☐ No If Yes, please provide details a. _____ since _____ dd/mm/yyyy b. _____ since _____ dd/mm/yyyy c. _____ since _____ dd/mm/yyyy		
19.	Insured's past medical history (if any) a. _____ _____ dd/mm/yyyy b. _____ _____ dd/mm/yyyy c. _____ _____ dd/mm/yyyy		
20.	Is the illness or condition related to: (please tick (√) if Yes a. Congenital / Hereditary ☐ e. Self-inflicted injuries / Violation of laws / Strike / Riots ☐ b. Influence of Drugs / Alcohol ☐ f. Cosmetic / Plastic surgery ☐ c. Anxiety / Mental / Nervous / Emotional disorder ☐ g. Dental care / refractive errors correction ☐ d. AIDS / STD / VD / HIV ☐ h. Pregnancy / Childbirth / Infertility / Caesarean section / Miscarriage or any complications arising therefrom ☐		
21.	Can this sickness or injury be treated as: a. Outpatient basis? ☐ Yes ☐ No b. Day surgery basis? ☐ Yes ☐ No (If No, please provide details)		
22.	Was the patient pregnant at the time of hospitalization? (For female patient only) ☐ Yes _____ months ☐ No		
23.	If hospitalization was due to accident, please indicate: Date:_____ dd/mm/yyyy Time:_____ am/pm Nature of accident: Extent of injury:		
24.	I hereby certify that I have personally examined and treated Patient for his / her injuries / illness described above and that the facts as stated above represent my medical opinion of his / her condition. _____ _____ _____ Date Name & Signature of Attending Doctor Doctor / Hospital Stamp		

PART II: To be Completed by Attending Doctor

Part II: Medical report

- Attending doctor to complete this page (for claims amount that above RM500).

**Disclaimer: BSIB reserve the right to request the medical report even if the claims amount is below RM500.

Thank You