takafulkeluarga
Sharia Life Insurance

Outpatient and Dental Claim Form

Bismillahirrahmanirrahiim

Please fill in the form in block letters and with pen

REQUIRED DOCUMENTS

1. This form must be completed and signed by the rightful employee/participant and is only valid for one employee/participant.
2. This form must be submitted to the Claim Department of PT Asuransi Takaful Keluarga no later than 30 calendar days upon the treatment, along with the required documents. Claim can only be processed upon submission of completed documents.
3. Checklist of required documents:
   - ☐ Completed claim form
   - ☐ Medical resume
   - ☐ Expense detail
   - ☐ Original payment receipt
   - ☐ Copy of prescription from Physician in charge
   - ☐ Copy of diagnostic examination result (EKG, X-ray, USG, CT Scan, MRI, etc) and Laboratory test (blood test, etc)

DATA OF PARTICIPANT (MUST BE COMPLETED)

1. Name of Company : ______________________ Name of Participant : ______________________
2. Policy No. : ______________________ Participant No. : ______________________
3. Home Address : ______________________ Phone/HP: ______________________
4. Transfer via : Bank Name : ______________________ Branch : ______________________
   Account No. : ______________________ Account holder : ______________________
5. Are there any other parties responsible for your injury/illness? If yes, please specify: ______________________

STATEMENT

I hereby declare that :

1. I grant the power to PT Asuransi Takaful Keluarga to obtain any information/medical record from physician/hospital or any other parties with diagnose, treatment or service provided to me, or to any other insured from my family in accordance with the prevailing law and regulation.
2. All statement given is true and I do not conceal any information required by this program. I agree that false statement shall result to the rejection of claim or cancellation of my participation.

______________________ , ____/____/____
Place Dt Mo Yr

Participant/Attorney Signature

____
Full name

PT. Asuransi Takaful Keluarga
Graha Takaful Indonesia Jl. Mampang Prapatan Raya No.100 Jakarta Selatan 12790 Indonesia | T. (021) 799 1234 | F. (021) 790 1435 | www.takaful.co.id
Layanan Peserta: (021) 7919 0005 | 0807 100 3456 | 0811 820 6531 (SMS)

Filled in by Physician (Please complete the form in block letters with pen)

CLAIM TYPE

1. Hospital/Clinic Name and Address : ____________________ Phone : ____________________
2. Date of Treatment : ____________________
3. Type of Treatment : ☐ General Practitioner Consultation ☐ Medical Specialist Consultation ☐ Dentist Consultation
   ☐ Treatments, Type/Name of Treatments ____________________

MEDICAL RESUME

1. Primary symptoms : ____________________
2. Additional symptoms : ____________________
3. First time symptoms occurrence : Date ____ Month ____________ Year ________
4. History of previous related disease or injury : ____________________
5. Physical Examination : ____________________
6. Laboratory : ____________________
7. Others supporting examination : ____________________
8. Diagnosist : ____________________
9. Therapy : ____________________
10. Follow up/suggestion : ____________________

CLASSIFICATION

Is the diagnosis related to

☐ Congenital Hereditary ☐ Pregnancy ☐ STD/HIV/AIDS ☐ Fertility ☐ Accident ☐ Cosmetic
☐ Psychosomatics ☐ Orthodentist ☐ Drug Abuse ☐ Tentamina Suicide ☐ Other, Specify ____________________

I, the Physician in charge, hereby declare that the above statement is complete and correct

Name of Physician in Charge	Physician Signature and Hospital Stamp
Phone No.	

Billing detail	
Doctor consultation	Rp.
Medicine	Rp.
Supporting examination	Rp.
Treatments/others	Rp.