



**Tokio Marine Vital Cover Insurance Claims - Health Questionnaire**

**Policy no :**

**Claim no :**

**Claimant :**

**Date of loss :**

We refer to the above claim and we would appreciate you could furnish the following information so that we can assess your claim accurately and fairly. Kindly sign the attached consent form and return for our further action.

1) Were you been admitted to hospital for Respiratory Disease or Covid 19 for the past 5 years?

Yes

No

1) If Yes, please provide your hospitalisation record

1) Date of admission : \_\_\_\_\_  
Date of Discharge : \_\_\_\_\_  
Name of Hospital : \_\_\_\_\_  
Doctor's name : \_\_\_\_\_  
Illness/Sickness : \_\_\_\_\_

2) Date of admission : \_\_\_\_\_  
Date of Discharge : \_\_\_\_\_  
Name of Hospital : \_\_\_\_\_  
Doctor's name : \_\_\_\_\_  
Illness/Sickness : \_\_\_\_\_

3) Date of admission : \_\_\_\_\_  
Date of Discharge : \_\_\_\_\_  
Name of Hospital : \_\_\_\_\_  
Doctor's name : \_\_\_\_\_  
Illness/Sickness : \_\_\_\_\_

*Notes : please provide a separate list should you have more than 3 admission records.*

Yours faithfully,

**TOKIO MARINE INSURANS (M) BERHAD**

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

Claimant :

Signature :

Fatiha Marzuki  
Health Department.

Date :



**DECLARATION & CONSENT**

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

I hereby irrevocably authorize any organization, 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 disability, to fully disclose to **TOKIO MARINE INSURANS (Malaysia) Berhad** or its authorized representative such information in relation to this claim.

Name : Signature :  
NRIC : Date :