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**International Medicare Group Sdn Bhd**
Registration No. 199801011498 (467626-A)
The Place, B-04, Level 4, Jalan USJ 25/1A, One City,
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Tel: +603-7661 6229

# LETTER OF CONSENT/ AUTHORISATION

| PATIENT ADMISSION DETAILS | |
|---|---|
| PATIENT NAME | COMPANY NAME |
| PATIENT ID (NRIC/ PASSPORT) | HOSPITAL NAME |
| MRN/ ADMISSION NUMBER | ADMISSION DATE AND TIME |
| DATE OF BIRTH/ AGE | PRINCIPAL'S NAME AND ID (NRIC/ PASSPORT) |

## PATIENT'S DECLARATION AND AUTHORISATION

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

I understand the delivery of this form is in no way to admission of claim by International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/ Employer Company and payment to the hospital by International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/ Employer Company nor will it represent a final admission of claim by International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/ Employer Company for this and any further claims arising and I agree that International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/Employer Company shall reserve all to evaluate and assess my claim as they deem appropriate.

I am fully aware of the limits as to my/ the covered person's medical entitlement under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my/ the covered person's entitlement under the said policy contract, or that is not covered by the same.

I hereby irrevocably permit disclosure to and authorise International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/ Employer Company to liaise with and receive from any organisation, institution, or individual that has any record of 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 or any other information that may assist International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/ Employer company to assess the validity/eligibility of my claim. I agree that International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/ Employer Company or its representative may use or disclose any of the information collected or held to third parties (including International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd.'s parent company, subsidiaries, or any other associated companies of International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd., including but not limited to reinsurers, medical examiners, claims investigators and industry associations/federations) in relation to this claim.

I agree that in the event I make or have in the past made any false or untrue statement, suppressed and/ or concealed any material facts in respect of my/ the covered person's condition, International Medicare Group Sdn. Bhd./ HealthMetrics Sdn. Bhd./ Insurer/ Employer company shall reserve the right to absolutely forfeit my/ the covered person's right to compensation and further reserves the right to recover from me/ the covered person any amounts paid previously for me/ the covered person as a result thereof.

| Signature of patient:<br><br>Full name:<br><br>Patient ID (NRIC/Passport):<br><br>Date: | Signature of principal/ claimant:<br><br>Full name:<br><br>Patient ID (NRIC/Passport):<br><br>Date:<br><br>Contact number:<br><br>Relaonship to patient: | Signature of witness:<br><br>Full name:<br><br>Patient ID (NRIC/Passport):<br><br>Date:<br><br>Contact number: |
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