FORM 34
NOTICE AND BENEFIT CLAIM DETAIL
EMPLOYEES' SOCIAL SECURITY (GENERAL) REGULATIONS 1971
(Regulations 46, 53, 56B, 58(3), 66(1), 68A(2), 71, 71A, 83(2), 88(1) and 98(1))

PERKESO

FORM 34 - NOTICE AND BENEFIT CLAIM DETAIL

THE OFFENCE OF FALSIFYING BENEFIT CLAIM INFORMATION CAN BE PUNISHED UNDER SECTION 93 OF THE EMPLOYEES' SOCIAL SECURITY ACT 1969; SECTION 18, OF THE MALAYSIAN ANTI-CORRUPTION COMMISSION ACT 2009; SECTION 193 OF THE PENAL CODE

IMPORTANT!
Tick (√) on the RELEVANT NOTICE:

- ☐ NOTICE OF EMPLOYMENT INJURY
- ☐ NOTICE OF NON-EMPLOYMENT INJURY
- ☐ NOTICE OF OCCUPATIONAL DISEASE
- ☐ NOTICE OF INVALIDITY
- ☐ NOTICE OF DEATH

A. INSURED PERSON DETAILS

A1. Full Name

A2. New NRIC No. - -

A3. Old NRIC No.

A4. Passport No. / Police No. / Army No. / Social Security No. (SSN)

A5. Date of Birth Day Month Year

A6. Race ☐ Malay ☐ Chinese ☐ Indian ☐ Sabah Bumiputera ☐ Sarawak Bumiputera ☐ Others:.....

A7. Gender ☐ Male ☐ Female

A8. Current Residential Address

Postcode State

A9. House Telephone -

A10. Mobile Telephone

A11. E-mail : .....

B. CURRENT EMPLOYER DETAILS

B1. Employer's Code

B2. Company Name

B3. Current Address

Postcode State

B4. Office Telephone

B5. Fax No.

B6. E-mail : .....

C. CURRENT EMPLOYMENT DETAILS

C1. Employment Commencement Date Day Month Year

C2. Occupation : .....

C3. Wages Paid By ☐ Monthly ☐ Daily

D. ACCIDENT NOTICE DETAILS

D1. Accident Date Day / Month / Year

D2. Time Of Accident : a.m / p.m

D3. Place Of Accident ☐ Inside Employer's Premise ☐ Outside Of Employer's Premise (Specify): .....

D4. Accident Arising Out Of And The Course Of Employment? ☐ Yes ☐ No

D5. If Yes, Please Describe How The Accident
☐ While Working
☐ During Employment Activities
☐ During Emergency
☐ During Journey Between Place of Residence and Place of Work
☐ During Work-Related Journey
☐ During Journey at Authorized Recess
☐ Others (Specify .....)

D6. Date Of Death *(If Fatal Accident)* Day / Month / Year

D7. Are Wages PaidOon The Day Of Accident? ☐ Yes ☐ No

D8. Injury Description

D9. Injured Body Parts ☐ Right ☐ Left

D10. An Insured Person Was Working On The Accident Date? ☐ Yes ☐ No

D11. Starting Time of Work On The Date of Accident am / pm

D12. Authorized Recess On The Date Of Accident am / pm

D13. Ending Time Of Work On The Date of Accident am / pm

D14. Name of Witness *(If Any)*

D15. Witness Telephone No. *(If Any)*

D16. Starting Date Of Medical Leave Day / Month / Year

D17. Name of the Attending Doctor

D18. Name & Address Of Clinic / Hospital Which Provides First Treatment

Attach:
1) ***Medical Certification/ Medical Leave Certificate [Reg. 57(1)]***
2) ***Police Report For Road Accident Related To Employment [Reg. 71(1)]***

E. OCCUPATIONAL DISEASE NOTICE DETAILS

E1. Name & Address Of Employer For The Last 5 Years Of Employment *(Please Provide An Attachment If There Is Insufficient Space)*

No.	Employer's Name & Address	Period Of Employment	Occupation

E2. Description Of Occupational Disease

E3. Is The Disease Related To Employment? ☐ Yes ☐ No

E4. Date Of Death *(If Applicable)* Day / Month / Year

E5. Specify Duties & How Insured Person Exposed To The Danger

E6. Explain Symptoms (Sign) Encountered

E7. Total Days Of Medical Leave *(If Any)* Days

E8. Period Of Medical Leave Day / Month / Year **Until** Day / Month / Year

E9. Name & Address Of Clinic/ Hospital Which Provides First Treatment

Attached Together A Medical Report in PERKESO Format [Reg. 68A(1)]

E10. Name Of The Attending Doctor

F. INVALIDITY NOTICE DETAILS

F1. Description Of Morbidity

F2. The Year Morbidity Is First Suffered

F3. Is The Insured Person Still Engaged In Employment? ☐ Yes ☐ No

F4. Date Of Cessation Of Employment *(If Applicable)* Day / Month / Year

F5. Employment Information:

No.	Employer's Name & Address	Period Of Employment	Designation

Attach the Medical Report In PERKESO Format [Reg. 46(ii)]

G. DEATH NOTICE DETAILS

G1. Date Of Death Day / Month / Year

G2. Time Of Death ☐ Work Related ☐ Not-Work Related

G3. Is The Death Due To Accident? ☐ Yes ☐ No
*(If '**Yes**', Please complete **D : ACCIDENT NOTICE DETAILS**)*

G4. Status Of Insured Person *(At the time of death)* ☐ Single ☐ Married ☐ Divorced

H. PREFERRED PERKESO OFFICE FOR DEALINGS

City

State

I. EMPLOYER'S / EMPLOYER'S REPRESENTATIVE'S DECLARATION

I hereby certify to the best of my knowledge and belief that all particulars given are true; and
(Please tick √ on the relevant box)

☐ **Certified that the insured person is employed by this employer and involved in an employment injury.**

☐ **Certified that the insured person is employed by this employer and involved in kemalangan non-employment**

☐ **Certified that the insured person is employed by this employer and involved in an accident during a period of unpaid leave and no contributions**.

☐ **Certified that the insured person is employed by this employer and is experiencing a serious illness.**

Signature Of Employer/ Employer's Representative : …….

Full Name :……...

Designation :…… Date Day / Month / Year

No signature is required if the submission of this form is via online

J. APPLICANT'S DECLARATION

Name of Claimant

Postal Address

Postcode State

New NRIC No./ Passport - -

Old NRIC No.

Other identification No. (*if any*)

House Phone No. -

Mobile No. -

E-mail :

I HEREBY CONFIRM THAT: ***** *Tick (√) on the relevant box***

☐ **I am a Recipient of Temporary Disablement Benefit** (FHUS) and did not attend work during the medical leave period. I am responsible to inform PERKESO if I attend to work and receive wages for any day during the medical leave period for which FHUS is not payable to me .

☐ **I have incurred expenses amounting to RM** - for the funeral management of the deceased insured person and wish to claim the Funeral Benefit. ***Attach the receipts for expenses if the claim is made by a person other than the deceased's family member.***

☐ **I am the eldest surviving *son or *daughter** of the deceased insured person and wish to claim the Funeral Benefit .

☐ **I am *a dependant or *the guardian of a dependant** of the deceased insured person and wish to claim any benefits to which I and/or the dependant(s) under my care are entitled.

☐ **Number of Dependents** Information are as follows:

No.	Dependent Name	NRIC No./ Birth Certificate	Date of Birth	Relationship with the Insured Person	Status *(For Children: Studying/ Disabled/ Married) (For Minor Brother/Sister: Married)*

Attach the documents as specified in the CHECKLIST [Reg. 56B & Reg. 88(1)]

Attach additional sheets, if the space provided is insufficient.

Personal bank account information for benefit's payment is as follow. *Attach proof document.*

Bank's Name: …… **Account No**.

I / Dependant will reporting responsibly and immediately to PERKRESO if there any changes with the benefit eligibility.
(Section 55, Employees' Social Security Act 1969)

I declare that the information and details given are correct to the best of my knowledge.

……
Signature / Thumbprint of the Claimant

Date Day Month Year

No signature is required if the submission of this form is via online

FOR PERKESO USE ONLY

Notice Date Received Day Month Year

Recipient's Signature: ……

Full Name: ……

Designation: ……

Stamp
Received Date