POLIKLINIK
SENTRAL
wholly owned by Mekar Medik Sdn Bhd

PANEL APPLICATION FORM

Company Main Details

Company Name : ____________________
Company Registration No : ____________________ No. of staff : __________
Type of industry : __________ Establish Year : __________

Company Contact Details

CEO / Manager : ____________________
Address : ____________________
____
Tel . No : __________
Fax : __________
Email : ____________________
website : ____________________

Applicant's Details / Person in Charge

Please key in details of your company representative for us to contact for verification and follow up purpose.

Fullname : ____________________
I/C : ____________________
Designation : ____________________

Please select medical coverage(s) which will be enfered to all your company's

☐ Employees only

☐ Employee's and dependants (family)

Remarks : ____________________

Please provide list of employees and dependants for our kind reference.

Entittlements

Common illness only	☐ Yes		
Vaccination / immunization	☐ Yes	☐ No	☐ Call HR first
Minor surgery	☐ Yes	☐ No	☐ Call HR first
Essential laboratory / urine tests	☐ Yes	☐ No	☐ Call HR first
Chest X-ray	☐ Yes	☐ No	☐ Call HR first
ECG	☐ Yes	☐ No	☐ Call HR first
Ultra-sound	☐ Yes	☐ No	☐ Call HR first
Periodic health screening	☐ Yes	☐ No	☐ Call HR first
Maternity related cases	☐ Yes	☐ No	☐ Call HR first
Long term / scheduled medication (Diabetes, HPT etc)	☐ Yes	☐ No	☐ Call HR first
Medical check up -eg: pre employment, pre University	☐ Yes	☐ No	☐ Call HR first

Others: ____________________

Charges

☐ Please charge according to clinic rates

☐ Please limit charges to maximum of RM______ per visit (except in emergency cases).

If the amount exceed this limit per visit :
☐ the employee (patient) to pay the difference
☐ to proceed and bill to company with itemised charges
☐ ________________________________

All medical bills will be paid via :

☐ IBG

☐ Cash - please provide us with transaction receipt as proof of payment

☐ Cheque - physical cheque must be sent to our company by postal.

All cheque , transaction receipt and payment voucher must be sent to us by email / postal / fax, addressed to :

Poliklinik Sentral,
Unit 3, Level 2, 50470 Stesen Sentral, Kuala Lumpur.
Tel : 03 - 2276 0808
Fax : 03 - 2276 0909
Email : psklsentral@gmail.com

Effective Date: ____________

I / We hereby agree to the terms and conditions mentioned in this letter. We shall pay all medical bills within 30 days from the date of receipt of invoice. Either party may terminate by giving 14 days written notice to the other party, and in such an event the outstanding bills shall be settled within 7 days from the date of such termination.

Authorised by :

Company Stamp :

Name :
Designation :

Date :

Please complete this form and return to us by email / fax to :
email : psklsentral@gmail.com
fax : 03 - 2276 0909

For more info kindly call Ms. Lenny at 013 - 983 5941 / 03 - 2276 0808