CLAIMS SUBMISSION REQUIREMENTS

Dear Claimant,

The following documents must be submitted in order to process the claim:-

Claim Type : BRAIN NERVE & MUSCLE RELATED CONDITION

1. Claimant Statement (Completed By Claimant) - enclosed
2. Doctor Statement (Completed By Doctor In-charge) – enclosed
3. Copy of I/C (Life Assured)
4. Copy of Salary Slip (Member)
5. CT Scan Report

Note: Kindly certify true copy on all documents that are not original copy. The supporting reports listed in No.5 must be obtained in order to process this claim without any interference or need for further queries by the insurer. Hence, by providing this report at the first submission, you will assure the claims process will be faster. If in any circumstance these report are not available, kindly provide us with a letter from the doctor confirming the non-existence of this report

Note: No liability is admitted by issuing this claim form

The completed documents can be returned to your union/organization or to us at:

PSM ASSOCIATES SDN BHD
Bangunan PSM, Level 4,
No. 17B, Jalan Bangsar, 59200 Kuala Lumpur.
Tel : 03-22821616 (Hunting Line)Fax : 03-22821919
H/Phone : 012-3072811 (Office)
Email: psmaniampsm@yahoo.com

CONFIDENTIAL MEDICAL CERTIFICATE
(LIVING ASSURANCE - BRAIN, NERVE & MUSCLE RELATED CONDITION)

Great Eastern
A member of the OCBC Group

Policy No. | | | | | | | | | | |
Policy No. | | | | | | | | | | |
Policy No. | | | | | | | | | | |
Policy No. | | | | | | | | | | |

New NRIC No. | | | | | | | - | | | - | | | | |
Old NRIC/Birth Certificate/ Passport No. | | | | | | | | | | | | | | | | | | | | |
Name of Life Assured _____

The above name is insured with GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted within the coverage of a Critical Illness benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any medical report fee incurred in completing this form, it will be borne by claimant)

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

- ☐ CT Scan / MRI report of the Brain
- ☐ MRI of Spine
- ☐ Lumbar puncture test report
- ☐ Electromyography (EMG) test results
- ☐ Nerve conduction study/ Evoked potential test
- ☐ Blood test reports
- ☐ Surgery report
- ☐ Histopathology examination (HPE)
- ☐ Biopsy report
- ☐ Other reports. Please give details: _____

1. Are you the Life Assured's usual medical attendant? ☐ Yes ☐ No

   If "YES", since what date? | | / | | / | | | | (dd/mm/yyyy)

2. Has the Life Assured previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?

   ☐ Yes ☐ No

   If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name and Address of Clinic / Hospital

3. Date when Life Assured FIRST consulted you for the illness. | | / | | / | | | | (dd/mm/yyyy)

4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Life Assured had been experiencing these symptoms.

Symptoms	Date symptoms first presented (dd/mm/yyyy)
(a)	
(b)	

What is the source of this information?

- ☐ Life Assured
- ☐ Referring doctor
  Name of doctor and hospital / clinic: _____
- ☐ Others, please specify: _____

5. Diagnosis

   (i) Please describe the full and exact diagnosis. (i) _____

   (ii) Date when the illness was FIRST diagnosed (ii) | | / | | / | | | | (dd/mm/yyyy)

   (iii) Diagnosis was FIRST made by (name of doctor and hospital) (iii) _____

   (iv) Date when Life Assured FIRST became aware of the illness. (iv) | | / | | / | | | | (dd/mm/yyyy)

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1-300-1-300-88 Fax: (603) 4259 8000
E-mail: wecare-my@greateasternlife.com Website: www.greateasternlife.com

6. What is the underlying cause of the illness as per diagnosis above?	
7. Type of investigations / tests done to confirm the diagnosis.	
8. Please give details of completed, planned or current treatment for the illness stated above.	
9. Is the Critical Illness associated with any other disorder, for example neurosis, psychiatric illness, HIV infection, etc.?	☐ Yes ☐ No If "YES", please give details.
10. The condition was associated with: (Please elaborate in details)	☐ self-inflicted injury ☐ drug or alcohol misuse ☐ Others:

11. Please tick and complete for the relevant sections:

√ Please tick	Items	Descriptions
☐ Stroke	Cause of stroke:	☐ Infarct ☐ Hemorrhage ☐ Embolus
☐ Parkinson's Disease	(i) Cause of Parkinson's Disease: (ii) Can the condition / illness be controlled with medication?	(i) ☐ Idiopathic ☐ Secondary due to: (ii) ☐ Yes ☐ No
☐ Motor Neuron Disease	Type of Motor Neuron Disease:	☐ Amyotrophic lateral sclerosis ☐ Progressive bulbar palsy ☐ Primary lateral sclerosis ☐ Spinal muscular atrophy
☐ Muscular Dystrophy	Type of Muscular Dystrophy:	☐ Duchenne's ☐ Myotonic ☐ Facioscapulohumeral ☐ Congenital ☐ Others:
☐ Alzheimer's Disease	Type of conditions involved:	☐ Alzheimer's disease ☐ Dementia ☐ Other degenerative brain disorders
☐ Major Head Trauma	What is the exact location and extent of the head injury?	
☐ Coma	(i) How long was the Life Assured in a state of coma, with no response to external stimuli? (ii) Was the coma 'Medically induced'? (iii) How long was the Life Assured on a ventilator?	(i) _____ hours / _____ days since ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) _____ am/pm (ii) ☐ Yes ☐ No (iii) _____ hours / _____ days First on ventilation since : ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
☐ Benign Brain Tumour	(i) Is the tumour life threatening? (ii) Are there signs of increased intracranial pressure? (iii) Has it caused damage to the brain?	(i) ☐ Yes ☐ No If "YES", please give details. (ii) ☐ Yes ☐ No If "YES", please give details. (iii) ☐ Yes ☐ No If "YES", please give details.

☑ Please tick	Items	Descriptions
☐ Bacterial Meningitis / Encephalitis	Please provide Cerebrospinal Fluid (CSF) test results	_____ _____ _____ _____ _____
☐ Brain Surgery	(i) Please state type of surgery: (ii) Reason for surgery: (iii) Was the surgery done due to injuries sustained during an accident? (iv) Please state date of surgery:	(i) ☐ Craniotomy ☐ Craniectomy ☐ Other procedure : _____ (ii) _____ (iii) ☐ Yes ☐ No (iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

12. Please provide us with any other information that will enable the Company to assess this claim.

_____

_____

13. **Neurological Examination report:**

Please state below **(Question a - h)**, the Life Assured's physical and neurological impairments, **based on latest / current assessment:**

Date when neurological impairments were first noted: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Date of latest/current assessment: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(a) Vision (Visual Acuity)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

(b) Hearing (Supported by an Audiometry results)

	Right	Left
Normal		
Impaired		
Scores based on speech reception threshold	dB	dB

Remarks: _____

(c) Function of speech

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Remarks: _____

(d) Cognitive function

☐ Normal
☐ Poor comprehension
☐ Difficult with logic and reasoning
☐ Memory loss

Remarks: _____

(e) General examination findings:

(i) Are there any abnormal movements or abnormal gait? (Please provide full details) — (i) _____

(ii) Is there any muscle wasting? (Please provide full details) — (ii) _____

(iii) If there are any other significant examination findings, please provide the details. — (iii) _____

(f) Examination of the Limbs

Please indicate the **muscle power** of the various joint in the table below with the maximum grade of 5.

Upper Limbs	**Right**	**Left**
Shoulder		
Elbow		
Wrist		
Grip		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

(g) Assessment of Activities of Daily Living

Activities of Daily Living	**Not Limited**	**Limited**	**Incapable**
Transfer (Getting in & out of a chair without physical assistance)			
Mobility (Ability to move from room to room without physical assistance)			
Continence (Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene)			
Dressing (Putting on & taking off all necessary items of clothing without assistance of another person)			
Bathing / Washing (Ability to wash in the bath or shower, including getting in & out of bath or shower or wash by any other means without assistance of another person)			
Eating (All task of getting food into the body without assistance of another person)			

(h) Any other significant neurological examination findings or disability details that are not stated above:

_____

_____

_____

14. What is the prognosis of the Life Assured's neurological impairments?

You may tick (√) more than one.

- ☐ Recovered
- ☐ Stable and improving
- ☐ Progressively worsening
- ☐ No change. Likely to be permanent
- ☐ For Multiple sclerosis - History of multiple exacerbations and remissions. Please indicate number of exacerbations since diagnosis: _____

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, certify that I have examined the above Life Assured and that I have answered the above questions are true and to the best of my knowledge and belief.

Name: _____

Address:

Signature and Official Stamp

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

LIVING ASSURANCE CLAIM FORM - PERSONAL STATEMENT
BORANG TUNTUTAN PENYAKIT KRITIKAL - KENYATAAN PERIBADI

Great Eastern

Policy No. *No. Polisi*

Policy No. *No. Polisi*

Policy No. *No. Polisi*

Policy No. *No. Polisi*

New NRIC No. *No. KP Baru*

Old NRIC/Birth Certificate/ Passport No. *No. KP Lama/Sijil Kelahiran/No. Pasport*

Name of Life Assured *Nama Hayat yang Diasuranskan*

Handphone No. *No. Telefon Bimbit*

A. LIFE ASSURED'S PARTICULARS *BUTIR-BUTIR HAYAT YANG DIASURANSKAN*

1. Current correspondence address *Alamat surat-menyurat terkini*

2. Occupation and exact duties *Pekerjaan dan tugas sebenar*

3. (a) Employer's / Business Name *Nama majikan / syarikat*

   (b) Company Registration Number *Nombor pendaftaran syarikat*

4. Employer's / Business' Full Address *Alamat lengkap majikan / syarikat*

5. Employer's / Business' telephone no. *No. telefon majikan / syarikat*

6. Does life assured have any insurance with other insurers? *Adakah hayat yang diasuranskan mempunyai polisi dengan syarikat insurans yang lain?*
   If "Yes", please provide the details.
   Jika "Ya", sila nyatakan butir-butir tersebut.

1. _____

2. _____

3a) _____

3b) _____

4. _____

Postcode *Poskod*: _____

5. _____

6. ☐ Yes *Ya* ☐ No *Tidak*

Policy No. *No. Polisi*	Company *Syarikat*

B. PAYMENT MODE *CARA PEMBAYARAN*

How do you wish to receive your claims cheque? *Bagaimana anda ingin menerima cek tuntutan anda?*

☐ Mail to current correspondence address. *Mel ke alamat surat-menyurat terkini*

☐ Through authorised personnel to collect cheque (please attach Letter of Authorisation). *Melalui nama yang diberi kuasa untuk mengutip cek bagi pihak (sila sertakan Surat Kebenaran)*

☐ To be collected by assured at Great Eastern's Office at _____
Dituntuti oleh asured di Pejabat Great Eastern

C. NATURE OF CLAIM AND RELATED DETAILS *JENIS TUNTUTAN DAN BUTIR-BUTIR BERKENAAN*

1. Describe fully the symptom(s) for which you consulted a medical practitioner. *Nyatakan sepenuhnya tanda-tanda yang menyebabkan anda berjumpa dengan pengamal perubatan?*

2. How long did you have the symptoms before you consulted a medical practitioner? *Berapa lama anda mengalami tanda-tanda tersebut sebelum berjumpa dengan pengamal perubatan?*

3. Date when you FIRST consulted a medical practitioner. *Tarikh anda MULA-MULA berjumpa dengan pengamal perubatan.*

4. Describe fully the extent and nature of your illness. *Nyatakan sepenuhnya tahap dan jenis penyakit.*

5. Have you previously suffered from, or received treatment for, a similar or related illness? *Pernahkah anda mengalami atau dirawat untuk penyakit yang serupa atau berkaitan?*

1. _____

2. _____

3. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*

4. _____

5. ☐ Yes *Ya* ☐ No *Tidak*

If "Yes", give full details. *Jika "Ya", berikan butir-butir lengkap*

_____

CLM-LAPSF-V04-122013

D. RECORD OF MEDICAL CONSULTATIONS *REKOD RAWATAN PERUBATAN*

1. Give below the details of all doctors or specialists who have been consulted in connection with your illness :-
Berikan butir-butir doktor atau pakar yang merawat anda untuk kecederaan di atas :-

Name *Nama*	Address *Alamat*	Consultation Date *Tarikh Rawatan*

2. If you were admitted to a hospital or similar institution, please supply the following details:
Jika anda masuk ke hospital atau lain-lain institusi, berikan butir-butir berikut:

Name of hospital or institution *Nama hospital atau institusi*	Date of Admission *Tarikh Masuk*	Date of Discharge *Tarikh Keluar*

3. Please provide the name and address of your regular doctor / clinic if different from above (1) or (2) :-
Sila berikan nama dan alamat pegawai perubatan / klinik yang anda biasa berjumpa, jika lain daripada (1) atau (2) yang di atas:-

E. GENERAL *UMUM*

Have any of your blood relatives suffered from a similar or related illness?
Pernahkah saudara sedarah anda mengalami penyakit yang serupa atau berkaitan?

☐ Yes *Ya* ☐ No *Tidak*

If "Yes", state the relationship of relatives, nature of illness and the date when the illness was first diagnosed. *Jika "Ya", nyatakan pertalian persaudaraan, jenis penyakit dan tarikh penyakit mula-mula didiagnoskan.*

DECLARATION & AUTHORISATION BY THE ASSURED / LIFE ASSURED
PENGAKUAN & PEMBERIKUASA OLEH ASURED / HAYAT YANG DIASURANSKAN

I declare the above answers are true, complete and correct, and agree that if I have made, or shall make any untrue statement, or suppressed or concealed any material fact; my/the Life Assured's right to be compensated shall be absolutely forfeited. I, the Life Assured/Assured, hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organization, institutions or persons that may have any records or knowledge of my/Life Assured's health or medical history ("Information Provider"), to provide such information to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("the Company") and its authorised service provider and/or its employees in order to process my insurance claim. I, the Life Assured/Assured, expressly waive on behalf or myself or any person who shall have any claim or interest in any policy hereunder, all provision of law or professional ethics forbidding any Information Provider from disclosing any information acquired while attending to me in a professional capacity. I, the Life Assured/Assured/Claimant, hereby authorise and give my consent, to the deduction of monies due to the Company from the claim proceeds payable pursuant to any policy hereunder, including but not limited to any Automatic Premium Loan, Cash Loan, overdue interests, premium due, advance benefit paid, erroneous payment and/or payment made in excess of any claim amount. This authorisation shall irrevocably bind my successors and assigns and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be effective and valid as the original.

Saya mengaku bahawa jawapan di atas adalah benar. Saya, Hayat Yang Diasuranskan/Asured, dengan ini memberi kuasa dan mengizinkan mana-mana pegawai perubatan, doctor, pakar bedah, klinik, hospital, pusat perubatan, syarikat insurans atau organisasi, institut atau orang perseorangan ("Pemberi Maklumat") yang mungkin mempunyai apa-apa rekod atau mengetahui pekerjaan, kewangan, kesihatan atau sejarah perubatan saya untuk memberi maklumat kepada GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) *("pihak Syarikat") atau mana-mana ejen/kakitangannya yang diberikuasa. Saya juga tidak ragu-ragu untuk mengetepikan bagi pihak saya dan/atau sebagai waris terdekat Asured dan untuk harta pusakanya segala peruntukan undang-undang atau etika prefesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai saya dalam bidang kuasa sebagai prefesional dan/atau pelanggan dan saya juga memberi pelepasan kepada Pemberi Maklumat ejen/kakitangannya daripada apa-apa liabiliti kerana memberi maklumat tersebut kepada pihak Syarikat. Saya, Hayat yang Diasuranskan/Asured/Penuntut dengan ini memberi kuasa dan kebenaran untuk menolak wang yang perlu dibayar kepada Syarikat daripada jumlah tuntutan yang boleh dibayar menurut sebarang polisi di bawah ini, termasuk dan tidak terhad kepada sebarang Pinjaman Premium Automatik, Pinjaman Tunai, tunggakan faedah, premium yang perlu dibayar, manfaat yang telah dibayar lebih awal, kesilapan pembayaran dan/atau pembayaran yang telah melebihi sebarang amaun tuntutan. Surat pemberikuasa/kebenaran ini adalah muktamad dan salinannya juga memberi hak dan pengesahan yang sama dengan yang asal.*

Signature of Life Assured *Tandatangan Hayat yang Diasuranskan*

Name *Nama* _____

NRIC No. *No. KP* _____

Date *Tarikh* _____

Signature of the Assured *Tandatangan Asured* (If different from the Life Assured) *(Jika lain daripada Hayat yang Diasuranskan)*

Name *Nama* _____

NRIC No. *No. KP* _____

Date *Tarikh* _____

Signature of Witness *Tandatangan Saksi*

Name *Nama* _____

NRIC No. *No. KP* _____

Tel. No. *No. Tel.* _____

Address *Alamat* _____

_____ Postcode *Poskod*: _____

Date *Tarikh* _____

AGENT'S / OFFICER'S DECLARATION *PENGAKUAN EJEN / PEGAWAI*

I hereby declare that I have sighted the original *NRIC/passport/birth certificate of the life assured and assured and verified the identity of the life assured and assured through the use of such *NRIC/passport/birth certificate. *Saya mengesahkan identiti hayat yang diasuranskan dan asured setelah melihat *kad pengenalan/paspot/sijil kelahiran yang asli.*

Signature of *agent / officer
*Tandatangan *ejen / pegawai*

Name *Nama* _____

Agent No. / Staff ID
No. Ejen / ID Pegawai _____

Date *Tarikh* _____

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LETTER OF AUTHORISATION/CONSENT - To Obtain Further Information for Non-Death

SURAT PEMBERIKUASA/KEBENARAN - Untuk Mendapatkan Maklumat Lanjut untuk Bukan Kematian

Great Eastern
A member of the OCBC Group

Policy No. *No. Polisi*
Policy No. *No. Polisi*
Policy No. *No. Polisi*
Policy No. *No. Polisi*

New NRIC No. *No. KP Baru* – –
Old NRIC/Birth Certificate/ Passport No. *No. KP Lama/Sijil Kelahiran/Paspot*
Name of Life Assured/Assured *Nama Hayat yang Diasuranskan/Asured*

To Whom It May Concern
Kepada Sesiapa Yang Berkenaan

Dear Sir/Madam,
Tuan/Puan,

I, the Life Assured/Assured, hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organization, institutions or persons that may have any records or knowledge of my/Life Assured's health or medical history ("Information Provider"), to provide such information to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("the Company") and its authorised service provider and/or its employees in order to process my insurance claim.

I, the Life Assured/Assured, expressly waive on behalf or myself or any person who shall have any claim or interest in any policy hereunder, all provision of law or professional ethics forbidding any Information Provider from disclosing any information acquired while attending to me in a professional capacity. This authorisation shall irrevocably bind my successors and assigns and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be effective and valid as the original.

This authorisation/consent is irrevocable and a copy of it will have the same effect and validity as the original.

Saya, Hayat Yang Diasuranskan/Asured, dengan ini memberi kuasa dan mengizinkan mana-mana pegawai perubatan, doktor, pakar bedah, klinik, hospital, pusat perubatan, syarikat insurans atau organisasi, institut atau orang perseorangan ("Pemberi Maklumat") yang mungkin mempunyai apa-apa rekod atau mengetahui pekerjaan, kewangan, kesihatan atau sejarah perubatan saya untuk memberi maklumat kepada GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("pihak Syarikat") atau mana-mana ejen/kakitangannya yang diberikuasa.

Saya juga tidak ragu-ragu untuk mengetepikan bagi pihak saya dan/atau sebagai waris terdekat Asured dan untuk harta pusakanya segala peruntukan undang-undang atau etika prefesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai saya dalam bidang kuasa sebagai prefesional dan/atau pelanggan dan saya juga memberi pelepasan kepada Pemberi Maklumat ejen/kakitangannya daripada apa-apa liabiliti kerana memberi maklumat tersebut kepada pihak Syarikat.

Surat pemberikuasa/kebenaran ini adalah muktamad dan salinannya juga memberi hak dan pengesahan yang sama dengan yang asal.

Signature or Thumb Print of Life Assured
Tandatangan atau Cap Ibu Jari Hayat yang Diasuranskan

Name *Nama*
NRIC No. *No. KP*
Date *Tarikh*

Signature or Thumb Print of the Assured
Tandatangan atau Cap Ibu Jari Asured
(If different from the Life Assured)
(Jika lain daripada Hayat yang Diasuranskan)

Name *Nama*
NRIC No. *No. KP*
Date *Tarikh*

GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)
Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1-300-1-300-88 Fax: (603) 4259 8000
Email: wecare-my@greateasternlife.com Website: www.greateasternlife.com