CLAIMS SUBMISSION REQUIREMENTS

Dear Claimant,

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

Claim Type : NATURAL DEATH / ACCIDENTAL CLAIM

1. Claimant Statement (CompleteBy Claimant) - enclosed
2. Doctor Statement (Complete By Doctor In-charge) - enclosed
3. Death Certificate
4. Copy of I/C (Member and spouse)
5. Marriage Certificate (spouse)
6. Copy of Salary Slip (Member)
7. Children Birth Certificate (if any)
8. Police Report
9. Post Mortem Report (if any)
10. Children Birth Certificate (if any

Note: Kindly certify true copy on all documents that are not original. The supporting reports listed in No.4 to No. 10 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

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

SURAT PEMBERIKUASA/KEBENARAN - Untuk Mendapatkan Maklumat Lanjut untuk Kematian

Great Eastern
A member of the OCBC Group

Policy No. *No. Polisi*		New NRIC No. *No. KP Baru*	– –
Policy No. *No. Polisi*		Old NRIC/Birth Certificate/ Passport No. *No. KP Lama/Sijil Kelahiran/Paspot*	
Policy No. *No. Polisi*		Name of Deceased *Nama Si Mati*	
Policy No. *No. Polisi*			

To Whom It May Concern
Kepada Sesiapa Yang Berkenaan

Dear Sir/Madam,
Tuan/Puan,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, insurance company or other organization, institution or individual concerned ("the Information Provider(s),") that may have any records or knowledge of the employment, financial, health or medical history of _____ ("the Assured") and to provide such information to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)("the Company) or its authorised agents and/or employees.

I expressly waive on behalf of myself and/or as a next-of-kin of the Assured and for his/her estate all provision of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on the Assured in a professional and/or client capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

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

Saya dengan ini memberi kuasa dan mengizinkan mana-mana pegawai perubatan, doktor, pakar bedah, klinik, hospital, pusat perubatan, syarikat insurans atau organisasi, institut atau orang perorangan ("Pemberi Maklumat") yang mungkin mempunyai apa-apa rekod atau mengetahui tentang pekerjaan, kewangan, kesihatan atau sejarah perubatan _____ ("Pemegang Polisi") untuk memberi maklumat kepada Great Eastern Life Assurance (Malaysia) Berhad ('Syarikat") atau mana-mana ejen/kakitangannya yang diberi kuasa.

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

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

Signature of Claimant
Tandatangan Penuntut

Name: _____
Nama
NRIC No.: _____
No. KP
Relationship with the Deceased: _____
Hubungan dengan Si Mati
Address: _____
Alamat _____
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

DEATH CLAIM FORM - DOCTOR STATEMENT

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 Deceased _____

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 for Death benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any fee incurred in completing this form, it will be borne by claimant)

SECTION I: DECEASED'S MEDICAL RECORD

1. Date of Death | | / | | / | | | | | (dd/mm/yyyy)

2. Height / Weight _____ (cm) _____ (kg)

3. Are you the Deceased's regular / family doctor? ☐ Yes ☐ No
If "YES", since what date? | | / | | / | | | | | (dd/mm/yyyy)

4. Has the Deceased previously suffered from or been 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 of Clinic / Hospital and Address

5. Did you attend to the Deceased's last illness? ☐ Yes ☐ No
If "YES",
(i) What were the symptoms presented? (i) _____
(ii) Date of symptoms started (ii) | | / | | / | | | | | (dd/mm/yyyy)
(iii) What was the diagnosis? (iii) _____

6. Was the Deceased hospitalised? ☐ Yes ☐ No
If "YES", please state the:
(i) Name of hospital admitted (i) _____
(ii) Date of First admission (ii) | | / | | / | | | | | (dd/mm/yyyy)
Date of Last admission | | / | | / | | | | | (dd/mm/yyyy)
(iii) Name(s) of attending doctor(s) (iii) _____

7. Was other doctor referring the Deceased to you? ☐ Yes ☐ No
If "YES", please state the name(s) and address(es) of the attending doctor(s) _____

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8. (i) Please state the disease(s) or condition(s) DIRECTLY leading to death with approximate interval between onset and death.

Cause of Death	Approximate Interval between onset and death			
	Years	Months	Days	Hours

(ii) Name of doctor(s) and hospital(s) that made the diagnosis.

(iii) Was the Deceased / family been informed of the diagnosis?

☐ Yes ☐ No ☐ Information unavailable

9. Was there any predisposing cause(s) of the Deceased's death in his/her habits (use of alcohol, narcotics, etc), family history, occupation or previous sickness?

☐ Yes ☐ No

If "YES", please provide details:

10. Any other information that you feel may be relevant?

SECTION II: This section is applicable to <u>ACCIDENTAL DEATH</u> only

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

☐ Post-mortem or Autopsy report ☐ Alcohol / drug test report

1. Date and Time of Accident: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) ☐☐ - ☐☐ (am/pm)

2. Nature of Accident (please tick only one)

☐ Road Traffic Accident ☐ Fall from Height / Building
☐ Drowning ☐ Industrial / Accident at Work
☐ Fire ☐ Air / Rail / Ship Disaster
☐ Explosion ☐ Sports Related
☐ Other: Please describe:

3. Please describe how the accident happen.

4. Was the Deceased suspected to be under the influence of any alcohol or drugs?

☐ Yes ☐ No

If "YES", was there any sample of urine or blood sent for further test?

☐ Yes ☐ No

5. In your opinion / investigation, do you think that death was resulted from the accident?

☐ Yes ☐ No

If "NO", what do you think was the cause of death? Please elaborate in detail.

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, do hereby declare that I have answered the above questions are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name:

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

DEATH CLAIM FORM
BORANG TUNTUTAN 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/Pasport*
Name of Deceased *Nama Si Mati*

A. DECEASED'S PARTICULARS *BUTIR-BUTIR SI MATI*

1. Last address *Alamat terakhir*

2. Nature of employment/business *Jenis pekerjaan/perniagaan*

3. Address of employer/business *Alamat majikan/perniagaan*

4. Marriage status at point of death *Status perkahwinan semasa kejadian mati*

5. Deceased's family member *Ahli keluarga Si Mati*

6. Religion *Agama**
*Nominee of Muslim deceased shall distribute the policy moneys in accordance with Islamic laws. *Penama kepada pemegang polisi yang beragama Islam haruslah mengagihkan wang tuntutan menurut Undang Undang Syariah.*

7. Does the Deceased have any insurance with other insurers? *Adakah Si Mati mempunyai polisi dengan syarikat insurans yang lain?*
If "Yes", please provide the details. *Jika "Ya", sila nyatakan butir-butir tersebut.*

1. _____
2. _____
3. _____
4. ☐ Single *Bujang* ☐ Married *Berkahwin* ☐ Divorced *Bercerai* ☐ Widow *Duda/Janda*
5. ☐ Spouse *Suami/Isteri* ☐ Father *Bapa* ☐ Mother *Ibu* ☐ Child(ren) *Anak-anak* _____ person *orang* ☐ Others. Please specify: _____ *Lain-lain. Sila nyatakan:*
6. ☐ Muslim *Islam* ☐ Non-Muslim *Bukan Islam*
7. ☐ Yes *Ya* ☐ No *Tidak*

Policy No. *No. Polisi*	Insurance Company *Syarikat Insurans*

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 claimant at Great Eastern's Office at _____ *Dituntuti oleh penuntut di Pejabat Great Eastern*

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

1. Cause of death *Sebab kematian* — 1. _____

2. For death due to Illness / natural death: *Bagi kematian kerana sakit / kematian biasa:* — 2. _____

(a) When did the Deceased first complain of, or give signs and symptoms of his / her last illness? *Bilakah Si Mati mula mengadu atau menunjukkan sebarang petanda penyakitnya yang terakhir?* — (a) _____

(b) When did the Deceased first consult a doctor for his / her last illness? *Bilakah Si Mati mula-mula berjumpa doktor untuk penyakitnya yang terakhir?* — (b) _____

(c) Name and address of doctor(s) who attended the Deceased for his / her last illness. *Nama dan alamat doktor-doktor yang merawat Si Mati semasa sakit terakhirnya.* — (c) _____

(d) Name and address of all doctors/hospitals who attended the Deceased for the last two years prior to death. *Nama dan alamat kesemua doktor/hospital yang merawat Si Mati dua tahun sebelum kematiannya.*

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

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Email: wecare-my@greateasternlife.com Website: www.greateasternlife.com

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

3. For death due to accident: *Bagi kematian kerana kemalangan:*	3.
(a) Date and time of accident *Tarikh dan waktu kemalangan*	(a) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)* _____ a.m. / p.m. *pagi / petang*
(b) Place of accident *Tempat kemalangan*	(b) _____
(c) How the accident happened? *Bagaimana kemalangan berlaku?*	(c) _____ _____
(d) Was the accident reported to the police? *Adakah kemalangan dilaporkan kepada polis?*	(d) ☐ Yes *Ya* ☐ No *Tidak*
(e) Was the accident reported in the newspaper? *Adakah kemalangan dilaporkan kepada di akhbar?*	(e) ☐ Yes *Ya* ☐ No *Tidak*
(f) Was the post-mortem carried out? *Adakah bedah siasat dilakukan?*	(f) ☐ Yes *Ya* ☐ No *Tidak*

DECLARATION & AUTHORISATION BY THE CLAIMANT *PENGAKUAN & PEMBERIKUASA OLEH PENUNTUT*

I am entitled to be the personal representative of the Deceased or I can act for and on behalf of all persons who may be entitled to apply for administration of the Deceased's estate. I declare that all answers given by me in this claim form are, to the best of my knowledge and belief, true and complete. I hereby authorise and give my consent to the Company to seek further information from 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 the Deceased's health or medical history ("Information Provider"), and expressly waive on behalf or myself and/or as next-of-kin of the Deceased and for his/her estate hereunder, all provision of law or professional ethics forbidding any Information Provider from disclosing any information acquired while attending to the Deceased in a professional capacity. I 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. I hereby declare that I have full right power and authority to grant the authorization and consent provided herein and, wherever applicable, have procure the consent of the person(s) entitled to the policy moneys.

I further agree that the furnishing of this claim form or any other supplemental forms by the Company will not be considered an admission that there was any insurance in force on the life of the Deceased with the Company or be deemed a waiver of the Company's right or defenses. This authorisation/consent is irrevocable and a copy of it will have the same effect and validity as the original.

Saya mengaku bahawa kesemua jawapan yang saya berikan di dalam borang tuntutan ini adalah benar dan lengkap menurut pengetahuan dan kepercayaan saya. Saya juga mengizinkan pihak Syarikat mengambil maklumat lanjut dari mana-mana pegawai perubatan, hospital atau klinik yang pernah merawat Si Mati atau majikan Si Mati sebelumnya atau dari mana-mana syarikat insurans yang Si Mati pernah mengemukakan borang cadangan, begitu juga dengan mengeluarkan maklumat tersebut. Dengan ini saya 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. Dengan ini saya mengisytiharkan bahawa saya mempunyai kuasa penuh untuk memberi kebenaran dan keizinan seperti diberi di dalam ini, mana yang berkenaan, dan telah mendapat izin daripada individu yang berhak ke atas wang polisi.

Saya juga bersetuju bahawa penerimaan borang tuntutan ini atau borang-borang tambahan yang lain oleh pihak Syarikat tidak dikira sebagai akuan bahawa semestinya insurans tersebut masih berkuat kuasa antara Si Mati dengan pihak Syarikat ataupun mengetepikan hak-hak atau pembelaan bagi pihak Syarikat.

Signature of Claimant
Tandatangan Penuntut

Are you the beneficiary of the policy(ies)? ☐ Yes *Ya* ☐ No *Tidak*
Adakah anda benefisiari kepada polisi ini?

Name *Nama* _____
NRIC No. *No. KP* _____
Relationship with the Deceased _____
Hubungan dengan Si Mati
Address _____
Alamat _____
Date *Tarikh* _____

Signature of Witness
Tandatangan Saksi

Name *Nama* _____
NRIC No. *No. KP* _____
Tel. No. *No. Tel.* _____
Address _____
Alamat _____
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 claimant and verified the identity of the life assured and claimant through the use of such *NRIC/passport/birth certificate. *Saya mengesahkan identiti hayat yang diasuranskan dan penuntut 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* _____