

## CLAIMS SUBMISSION REQUIREMENTS

Dear Claimant,

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

### **Claim Type : HOSPITAL BENEFITS**

1. Group Hospital Benefits Form (Complete By Claimant) – enclosed
2. Potostat I/c
3. Discharge Note preferably or any other official document to prove the admission and discharge
4. Direct Credit Facility Form

Note: Kindly certify true copy on all documents that are not original. The supporting reports listed in No.2 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. 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](mailto:psmaniampsm@yahoo.com)

**GROUP HOSPITALISATION BENEFIT (HB) CLAIM FORM**  
**BORANG TUNTUTAN FAEDAH HOSPITAL BERKELOMPOK**



Scheme No. No. Skim	G S	New NRIC No. No. KP Baru	
Contract No. No. Kontrak		Old NRIC/BC/Passport No. No. KP Lama/Sijil Kelahiran/ Pasport	
Date of Birth Tarikh Lahir		Name of Life Assured Nama Hayat yang Diasuranskan	
Handphone No. No. Telefon Bimbit		<input type="checkbox"/> Member Ahli <input type="checkbox"/> Spouse Suami Isteri <input type="checkbox"/> Dependent Tanggungan	

**IMPORTANT NOTICE NOTIS PENTING :**

Hospitalisation Benefit would not be paid if *Faedah Hospital tidak akan dibayar jika :*

- (a) It is a pre-existing illness or accidents which happens before the first premium payment, or while the Policy is under lapse status.  
*Disebabkan oleh penyakit atau kecederaan yang berlaku sebelum pembayaran premium pertama, atau semasa Polisi ini di dalam keadaan luput.*
- (b) In the first 6 weeks after the Policy is reinstated, unless the injury is due to accident.  
*Dalam jangkamasa 6 minggu pertama selepas Polisi dihidupkan semula, kecuali kecederaan disebabkan oleh kemalangan.*

<b>1. Life Assured Details Butiran Hayat Yang Diasuranskan</b>	
(a) Age Umur	
(b) Occupation Pekerja	
(c) Current correspondence address Alamat surat-menyurat terkini	
<b>2. Claimant's details (if other than Life Assured) Butiran Penuntut (Jika selain daripada Hayat Yang Diasuranskan)</b>	
(a) Claimant Name Nama Penuntut	
(b) NRIC No. No. Kad Pengenalan	
(c) Correspondence address Alamat surat-menyurat	
<b>3. Details of Hospitalisation Butiran Kemasukkan Hospital</b>	
(a) Hospital Name Nama hospital	
(b) Date of Admission Tarikh Masuk	
(c) Date of Discharge Tarikh Keluar	
(d) What was the diagnosis? Apakah diagnosis ketika itu?	

**MEDICAL INFORMATION AUTHORISATION AND DECLARATION KEBENARAN MAKLUMAT KESIHATAN/PERUBATAN DAN PENGAKUAN**

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 authorize 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 Providers"), to provide such information to the Company and its authorized service provider and/or its employees in order to process my insurance claim, and 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, hereby authorize 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. This authorization shall irrevocably bind my successors, assigns and, wherever applicable, the person(s) entitled to the policy moneys, and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be effective.

*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 saya 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 menyetujui segala harta pusakanya segala peruntukan undang-undang atau etika profesional yang menghalang. 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. Pemberi Maklumat daripada memberi maklumat berkenaan mengenai saya 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 the Claimant (Assured Member)  
Tandatangan Penuntut (Ahli)

Signature of the Life Assured (Patient)  
Tandatangan Hayat Yang Diasuranskan (Pesakit)

Date  
Tarikh

**DECLARATION BY UNION OFFICER PENGAKUAN OLEH PEGAWAI UNION**

I hereby confirm the above statements are full, complete and true to the best of my knowledge.

*Saya dengan ini mengesahkan bahawa semua maklumat tersebut di atas adalah benar dan betul sejauh yang saya tahu.*

Signature Tandatangan

Designation Jawatan

Date Tarikh

**Direct Credit Facility Kemudahan Pindahan Terus**

Claim payment of RM2,000.00 and below, will be credited directly into your bank account. Kindly complete the enclosed Direct Credit Facility Form.

*Pembayaran bagi tuntutan RM2,000.00 kebawah, akan dikreditkan terus ke akaun bank anda. Sila lengkapkan Borang Kemudahan Kredit Langsung yang dilampirkan.*

CLM-FBCLM-V00-112013

**DIRECT CREDIT FACILITY FORM  
(GROUP HOSPITALISATION BENEFIT CLAIM)**



**Term & Conditions**

1. In relation to claims made by an Assured Member or an Assured Spouse, payments made under this Direct Credit Facility shall be credited to the bank account of the Life Assured. However, claims in respect of an Assured Child may only be made by, and shall be paid into the bank account of the Assured Member only.
  2. A copy of a bank statement/first page of bank passbook with account details, duly signed by the owner ("Policy Owner") of the policy set out in this Direct Facility Form ("Policy"), is to be attached together with this Direct Credit Facility Form. The Company reserves the right to request for further and other documents to support this request for Direct Credit Facility.
  3. Direct Credit Facility is only available for direct credit to banks participating in the Interbank Giro payment system (IBG).
  4. Direct crediting of claims payment into the following accounts are not allowed:
    - (a) Overseas bank account;
    - (b) Corporate bank account (for keyman policy, mortgage reducing term assurance policy and employee benefit policy); and
    - (c) Any local bank account that is not in the name of the legitimate Policy Owner as stated in this Direct Credit Facility Form.
  5. Any use of correction fluid on document(s) required for the purposes of this request for Direct Credit Facility will not be accepted.
- Great Eastern Life Assurance (Malaysia) Berhad ("Company") reserves the right to release claims payment by cheque if the Company finds that any information and/or document(s) provided in or submitted with this Direct Credit Facility Form is incomplete, invalid and/or inconsistent.

Contract No.	G S <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
Name of Assured Member	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>
NRIC No. / Passport No.	<input style="width: 100%; height: 20px;" type="text"/>
Name of Bank	<input style="width: 100%; height: 20px;" type="text"/>
Bank Account Holder Full Name	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>
Bank Account No.	<input style="width: 100%; height: 20px;" type="text"/>
Account Type	<input type="checkbox"/> Single Account <input type="checkbox"/> Joint Account
Email Address	<input style="width: 100%; height: 20px;" type="text"/>

1. Please credit the amount payable into my selected bank account as stated above.\*
2. I confirm that I am the holder of the bank account specified above ("Account") and that the details thereof are correct, true and complete. I further confirm that I have full power and authority to operate the Account.
3. I authorize the Company to deposit claims payments which are payable to me into the Account. I agree that all further claims payment which are payable arising from the same claims event shall be paid into the Account, unless I notify the Company otherwise.
4. I acknowledge and agree that the claims payment into the Account shall be a valid discharge of the Company's liability under the Policy. I further agree that the Company shall not be held liable for any damages, losses, claims, cost and/or expenses which I may incur as a result of such payments made into the Account in accordance with my instructions herein.
5. I agree to immediately refund to the Company in full any monies paid into the Account which I am not entitled to receive.
6. I agree to indemnify the Company for any damages, losses, claims, cost and/or expenses incurred by the Company arising from or in connection with payments made to the Account in accordance with my instructions herein.
7. I hereby declare that I am not an undischarged bankrupt.

**Signature of the Life Assured\***

*\* For claims made in respect of Assured Child, to be signed by the Assured Member.*

Tel No (HP)    +    -

Tel No (House)    +    -

Date     /  /

Day                      Month                      Year

**Signature of Witness**

Name : \_\_\_\_\_

NRIC : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_

Contact No. : \_\_\_\_\_

**For Office Use Only**

Details verified against

Bank Statement/Account book

NRIC/Passport

Life Assured's signature

Others \_\_\_\_\_

Verified By : \_\_\_\_\_

Date : \_\_\_\_\_

CLM-GPDCF-V00-112013

IBG facility is only available to the following GIRO participating banks:-

(Date Updated: 14 January 2009)

No.	Financial Institution	No.	Financial Institution
1.	OCBC Bank	11.	Deutsche Bank (M) Sdn Bhd
2.	Affin Bank	12.	Hong Leong Bank
3.	Alliance Bank	13.	HSBC Bank
4.	AmBank	14.	Maybank
5.	Bank Islam Malaysia	15.	Public Bank
6.	Bank Rakyat	16.	RHB Bank
7.	Bank Muamalat	17.	Standard Chartered Bank
8.	Bank Simpanan Nasional	18.	UOB Bank
9.	Bumiputra Commerce Bank / CIMB	19.	The Royal Bank of Scotland Berhad
10.	Citibank	20.	Bank of America (Malaysia) Berhad