CLAIMS SUBMISSION REQUIREMENTS

Dear Claimant,

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

Claim Type : HEART RELATED CONDITIONS

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. ECG
6. CPK-MB,Troponin T/Tropoini I
7. Echocardiogram report
8. Coronary angiogram report
9. Other report

Note: Kindly certify true copy on all documents that are not original copy. The supporting reports listed in No.5 to No. 9 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, Fax no: 03-22821919
Email: psmaniampsm@yahoo.com

CONFIDENTIAL MEDICAL CERTIFICATE
(LIVING ASSURANCE - HEART RELATED CONDITIONS)

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 in 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)

Section 1: This section is COMPULSORY to be completed for all Critical Illnesses

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 and time when the illness was FIRST diagnosed (ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) ________ a.m. / p.m.

   (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)

6. Type of investigations / tests done to confirm the diagnosis. ______________________________

7. Please give details of completed, planned or current treatment for the illness stated above. ______________________________

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8. Is there any heart failure / cardiac impairment at present (at the time of completion of this report)? ☐ Yes ☐ No
If '"YES":
   (i) Please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification — (i) Class ☐ I ☐ II ☐ III ☐ IV
   Please provide details of current limitations ____________________
   (ii) Is the cardiac impairment likely to be permanent? — (ii) ☐ Yes ☐ No
   (iii) Will the cardiac impairment improve? — (iii) ☐ Yes ☐ No

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

Section 2: This section is applicable to specific Critical Illness only

A. To Be Completed for:
- **Heart Attack / Myocardial Infarction (MI), OR**
- **Coronary Artery By-pass Surgery, OR**
- **Other Serious Coronary Artery Disease, OR**
- **Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease**
- **Severe Cardiomyopathy, OR**
- **Primary Pulmonary Arterial Hypertension, OR**

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

☐ All serial Electrocardiogram (ECG)
☐ All Cardiac Enzymes (CPK-MB, Troponin T/ Troponin I)
☐ Echocardiogram report
☐ Percutaneous Coronary Intervention (PCI) or Laser treatment report
☐ Other reports. Please give details: ____________________
☐ Coronary angiogram report
☐ Coronary Artery By-pass Graft operation report
☐ Cardiac catheterization report

1. For illness of Heart Attack / Myocardial Infarction, please give the details of investigations / tests done that confirm the diagnosis.

	Date and time	Investigations / tests result
Cardiac marker (CK / CPK-MB / Troponin T or I)		
ECG		
ECHO / Others:		

2. Please complete the following:

(i) Please specify the coronary arteries involved and the percentage of stenosis:

Major Coronary Artery	Stenosis		Percentage (%) of stenosis
	YES	NO	
Left Main Stem			
Left Anterior Descending Artery			
Left Circumflex Artery			
Right Coronary Artery			
If other than above, please specify in details:			

Please give details of procedure / surgery performed.

(ii)

Tick (√)	Procedure/ surgery performed	Date and time of the surgery	Name of doctor who performed surgery, hospital & address
☐	Coronary Artery By-pass Graft via open-chest surgery		
☐	Percutaneous Coronary Intervention (PCI)		
☐	Others, please specify:		

3. Please complete the questions if the Life Assured have cardiomyopathy or primary pulmonary hypertension:
   (i) Details of investigations performed to confirm the diagnosis. — (i) ______
   (ii) What is the underlying cause of the cardiomyopathy / pulmonary hypertension? — (ii) ______
   (iii) Since when did the Life Assured have the underlying cause? — (iii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
   (iv) Is the cardiomyopathy due to alcohol or drug misuse / abuse? — (iv) ☐ Yes ☐ No
   If "YES", please provide details. ______

B. To Be Completed for:
- Heart Valve Surgery, OR
- Surgery to Aorta

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

☐ Heart valve surgery report
☐ Echocardiogram report
☐ Aortic surgery report
☐ Angiogram report
☐ Other reports. Please give details: ______

1. Type of surgery performed	______
2. Date of surgery	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
3. Name of doctor who performed the surgery, with name of hospital and address	______
4. For Heart valve surgery: (i) The approach was via : (ii) The procedure done was:	(i) ☐ open heart surgery ☐ intra-arterial procedure ☐ key-hole procedure ☐ others : ______ (ii) ☐ valvotomy / valvuloplasty ☐ valve repair ☐ valve replacement
5. For Surgery to aorta: (i) The approach was via : (ii) The surgery was performed for : (iii) The surgery was performed at :	(i) ☐ thoracotomy ☐ catheter based techniques ☐ laparotomy ☐ key-hole procedure ☐ intra-arterial procedure (ii) ☐ aneurysm ☐ obstruction ☐ dissection ☐ coarctation ☐ others : ______ (iii) ☐ thoracic aorta ☐ abdominal aorta ☐ aortic branches : ______

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.

Signature and Official Stamp

Name: ______

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

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

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* — 1. ____________
2. Occupation and exact duties *Pekerjaan dan tugas sebenar* — 2. ____________
3. (a) Employer's / Business Name *Nama majikan / syarikat* — 3a) ____________

   (b) Company Registration Number *Nombor pendaftaran syarikat* — 3b) ____________
4. Employer's / Business' Full Address *Alamat lengkap majikan / syarikat* — 4. ____________ Postcode *Poskod*: ______
5. Employer's / Business' telephone no. *No. telefon majikan / syarikat* — 5. ____________
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.

   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?* — 1. ____________
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?* — 2. ____________
3. Date when you FIRST consulted a medical practitioner. *Tarikh anda MULA-MULA berjumpa dengan pengamal perubatan.* — 3. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
4. Describe fully the extent and nature of your illness. *Nyatakan sepenuhnya tahap dan jenis penyakit.* — 4. ____________
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?* — 5. ☐ Yes *Ya* ☐ No *Tidak*

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

CLM-LAPSF-V04-122013

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline (603) 4259 8333 Agent Service Careline (603) 4259 8111 Fax (603) 4259 8198
E-mail wecare@lifeisgreat.com.my Website www.lifeisgreat.com.my

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.*

Name *Nama* ______________________

NRIC No. *No. KP* ______________________

Date *Tarikh* ______________________

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)*

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.*

Name *Nama* ______________________

Agent No. / Staff ID *No. Ejen / ID Pegawai* ______________________

Date *Tarikh* ______________________

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

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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

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* ______________

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