

## CLAIMS SUBMISSION REQUIREMENTS

Dear Claimant,

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

### **Claim Type : OTHER ILLINES**

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. Any Reports from Dotor.

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, Fax no: 03-22821919  
Email: [psmaniampsm@yahoo.com](mailto:psmaniampsm@yahoo.com)

**CONFIDENTIAL MEDICAL CERTIFICATE  
(LIVING ASSURANCE - OTHER ILLNESSES)**



Policy No. <input style="width:100%;" type="text"/>	New NRIC No. <input style="width:100%;" type="text"/>
Policy No. <input style="width:100%;" type="text"/>	Old NRIC/Birth Certificate/ Passport No. <input style="width:100%;" type="text"/>
Policy No. <input style="width:100%;" type="text"/>	Name of Life Assured _____
Policy No. <input style="width:100%;" type="text"/>	

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)

**Claims Condition Suffered (Please tick (√) where applicable)**

- |                                                                                  |                                                               |                                                        |
|----------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Kidney Failure                                          | <input type="checkbox"/> Fulminant Hepatitis                  | <input type="checkbox"/> Major Organ Transplant        |
| <input type="checkbox"/> Total Permanent Blindness                               | <input type="checkbox"/> End Stage Liver Disease              | <input type="checkbox"/> Terminal Illness              |
| <input type="checkbox"/> Total Permanent Deafness                                | <input type="checkbox"/> End Stage Lung Disease               | <input type="checkbox"/> Aplastic Anaemia              |
| <input type="checkbox"/> Loss of Speech                                          | <input type="checkbox"/> HIV Infection From Blood Transfusion | <input type="checkbox"/> Full Blown AIDS               |
| <input type="checkbox"/> Major Burns                                             | <input type="checkbox"/> AIDS Cover of Medical Staffs         | <input type="checkbox"/> Loss of Independent Existence |
| <input type="checkbox"/> Systemic Lupus Erythematosus (SLE) with Lupus Nephritis |                                                               |                                                        |

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) <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> / <input style="width:40px;" type="text"/> (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) <input style="width:20px;" type="text"/> / <input style="width:20px;" type="text"/> / <input style="width:40px;" type="text"/> (dd/mm/yyyy)
(v) What is the underlying cause of the illness as per diagnosis above?	(v) _____

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(vi) When was the underlying cause FIRST diagnosed?	(vi) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) Name of treating doctor and clinic / hospital. _____ _____ _____
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.	_____ _____ _____
8. What is the current condition of the Life Assured and what is the prognosis?	_____ _____ _____
9. Please provide us with any other information that will enable the Company to assess this claim. _____ _____ _____	

**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.

<div style="border: 1px solid black; height: 96px; width: 100%;"></div>	Name: _____
	Address: _____
Signature and Official Stamp	Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)

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



Policy No. No. Polisi	<input type="text"/>	New NRIC No. No. KP Baru	<input type="text"/> - <input type="text"/> - <input type="text"/>
Policy No. No. Polisi	<input type="text"/>	Old NRIC/Birth Certificate/ Passport No.	<input type="text"/>
Policy No. No. Polisi	<input type="text"/>	No. KP Lama/Sijil Kelahiran/No. Pasport	
Policy No. No. Polisi	<input type="text"/>	Name of Life Assured Nama Hayat yang Diasuranskan	<input type="text"/>
		Handphone No. No. Telefon Bimbit	<input type="text"/> - <input type="text"/>

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

1. Current correspondence address <i>Alamat surat-menyurat terkini</i>	1. _____ _____								
2. Occupation and exact duties <i>Pekerjaan dan tugas sebenar</i>	2. _____								
3. (a) Employer's / Business Name <i>Nama majikan / syarikat</i>	3a) _____								
(b) Company Registration Number <i>Nombor pendaftaran syarikat</i>	3b) _____								
4. Employer's / Business' Full Address <i>Alamat lengkap majikan / syarikat</i>	4. _____ _____								
	Postcode <i>Poskod</i> : _____								
5. Employer's / Business' telephone no. <i>No. telefon majikan / syarikat</i>	5. _____								
6. Does life assured have any insurance with other insurers? <i>Adakah hayat yang diasuranskan mempunyai polisi dengan syarikat insurans yang lain?</i> If "Yes", please provide the details. <i>Jika "Ya", sila nyatakan butir-butir tersebut.</i>	6. <input type="checkbox"/> Yes <i>Ya</i> <input type="checkbox"/> No <i>Tidak</i> <table border="1"> <thead> <tr> <th>Policy No. <i>No. Polisi</i></th> <th>Company <i>Syarikat</i></th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Policy No. <i>No. Polisi</i>	Company <i>Syarikat</i>						
Policy No. <i>No. Polisi</i>	Company <i>Syarikat</i>								

**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. <i>Nyatakan sepenuhnya tanda-tanda yang menyebabkan anda berjumpa dengan pengamal perubatan?</i>	1. _____ _____
2. How long did you have the symptoms before you consulted a medical practitioner? <i>Berapa lama anda mengalami tanda-tanda tersebut sebelum berjumpa dengan pengamal perubatan?</i>	2. _____
3. Date when you FIRST consulted a medical practitioner. <i>Tarikh anda MULA-MULA berjumpa dengan pengamal perubatan.</i>	3. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) (hh/bb/tttt)
4. Describe fully the extent and nature of your illness. <i>Nyatakan sepenuhnya tahap dan jenis penyakit.</i>	4. _____ _____
5. Have you previously suffered from, or received treatment for, a similar or related illness? <i>Pernahkah anda mengalami atau dirawat untuk penyakit yang serupa atau berkaitan?</i>	5. <input type="checkbox"/> Yes <i>Ya</i> <input type="checkbox"/> No <i>Tidak</i> If "Yes", give full details. <i>Jika "Ya", berikan butir-butir lengkap</i> _____ _____

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**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 <i>Nama</i>	Address <i>Alamat</i>	Consultation Date <i>Tarikh Rawatan</i>

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 <i>Nama hospital atau institusi</i>	Date of Admission <i>Tarikh Masuk</i>	Date of Discharge <i>Tarikh Keluar</i>

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:-*

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**E. GENERAL UMUM**

Have any of your blood relatives suffered from a similar or related illness?

*Pernakah 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.*

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**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 diberi kuasa. 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 profesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai saya dalam bidang kuasa sebagai profesional 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)*

Name *Nama* \_\_\_\_\_NRIC No. *No. KP* \_\_\_\_\_Tel. No. *No. Tel.* \_\_\_\_\_Signature of Witness *Tandatangan Saksi*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/pasport/sijil kelahiran yang asli.*

Name *Nama* \_\_\_\_\_

Agent No. / Staff ID \_\_\_\_\_

*No. Ejen / ID* \_\_\_\_\_*Pegawai* \_\_\_\_\_Signature of \*agent / officer  
*Tandatangan \*ejen / 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**



Policy No. <i>No. Polisi</i>	<input type="text"/>	New NRIC No. <i>No. KP Baru</i>	<input type="text"/> - <input type="text"/> - <input type="text"/>
Policy No. <i>No. Polisi</i>	<input type="text"/>	Old NRIC/Birth Certificate/ Passport No. <i>No. KP Lama/Sijil Kelahiran/Pasport</i>	<input type="text"/>
Policy No. <i>No. Polisi</i>	<input type="text"/>	Name of Life Assured/Assured <i>Nama Hayat yang Diasuranskan/Asured</i>	<input type="text"/>
Policy No. <i>No. Polisi</i>	<input type="text"/>		

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 diberi kuasa.*

*Saya juga tidak ragu-ragu untuk menyetujui bagi pihak saya dan/atau sebagai waris terdekat Asured dan untuk harta pusakanya segala peruntukan undang-undang atau etika profesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai saya dalam bidang kuasa sebagai profesional 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* \_\_\_\_\_