CLAIMS SUBMISSION REQUIREMENTS

Dear Claimant,

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

Claim Type : TOTAL & PERMANENT DISABILITY BENEFITS

1. Total And Permanent Disability Benefits Form (Complete By Claimant) - enclosed
2. Total And Permanent Disability Benefits Form (Complete By Doctor In-charge) – enclosed
3. Copy of I/C (Life Assured)
4. Copy of Salary Slip (Member)
5. Police Report (if any)
6. SOCSO Offer Letter
7. Termination of Service by the Employer

Note: Kindly certify true copy on all documents that are not original. The supporting reports listed in No.6 and No. 7 must be obtained in order to process this claim without any interference or need for further queries by the insurer. Hence, by providing these reports at the first submission, you will assure the claims process will be faster. In any circumstance these reports are not available, kindly provide 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
Wisma PSM
No. 17B, Jalan Bangsar, 59200 Kuala Lumpur.
Tel : 03-22821616 (Hunting Line)
Fax : 03-22821919
H/Phone : 012-3072811 (Office)

TOTAL AND PERMANENT DISABILITY BENEFITS CLAIM FORM
BORANG TUNTUTAN FAEDAH HILANG UPAYA TOTAL & KEKAL

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*
1. _____

2. Occupation and exact duties *Pekerjaan dan kerja sebenar*
2. _____

3. a) Employer's/Business Name *Nama majikan/syarikat*
   b) Company Registration No. *No. Pendaftaran Syarikat*
3a) _____
3b) _____

4. Employer's/Business's 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?*

☐ Direct credit (please attach Direct Credit Form for Claims) *Kredit Langsung (sila sertakan Borang Kredit Langsung bagi Tuntutan)*

☐ 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. 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 disability:-
Berikan butir-butir doktor atau pakar yang merawat anda untuk hilang upaya di bawah:-

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 dimasukkan 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 :-

_____
_____
_____

CLM-TPDCF-V04-122013

D. GENERAL *UMUM*

1. What is the highest level of education do you have?
   Tahap pendidikan tertinggi yang diperolehi?
   1. ☐ Primary *Sekolah rendah* ☐ Degree *Ijazah*
      ☐ Secondary *Sekolah menengah* ☐ Post Graduate *Lepasan Ijazah*
      ☐ Diploma *Diploma* ☐ Others *Lain-lain* _____
2. Are you currently confined to
   Adakah anda kini terlantar di
   2. ☐ Bed *Katil* ☐ House *Rumah* ☐ Hospital *Hospital*
3. When were you last able to work?
   Tarikh terakhir anda boleh bekerja?
   3. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
4. State the date when you are expected to resume your work and daily activities.
   Nyatakan tarikh anda dijangka kembali bekerja dan menjalankan aktiviti harian anda.
   4. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
5. If your service is terminated, please confirm the effective date.
   Jika perkhidmatan anda ditamatkan, sila nyatakan tarikh berkuatkuasa.
   5. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*

E. PARTICULARS OF OCCUPATION *BUTIR-BUTIR PEKERJAAN*

Please list the jobs held in the past 3 years. *Senaraikan pekerjaan anda untuk tempoh 3 tahun yang lepas.*

Dates (From - To) *Tarikh (Dari - Hingga)*	Job Title *Nama Jawatan*	Employer's Address *Alamat Majikan*	Exact Duties of Work *Jenis Kerja Sebenar*	Average Monthly Income (RM) *Pendapatan Purata Bulanan (RM)*

F. PARTICULARS OF LATEST EMPLOYMENT *BUTIR-BUTIR PEKERJAAN TERKINI (SILA NYATAKAN DENGAN LANJUT)*

WORK AREA *SKOP PEKERJAAN*

1. What kind of environment do you work in?
   Persekitaran tempat kerja anda?
   1. ☐ Office *Pejabat* ☐ Factory *Kilang* ☐ Others *Lain-lain* _____
2. Are you in management or supervisory capacity?
   Adakah anda menjalankan tugas-tugas pengurusan atau penyeliaan?
   2. ☐ Yes *Ya* ☐ No *Tidak*
3. Do you operate any machinery or special equipments?
   Adakah anda mengendalikan mesin atau alat-alat khas yang lain?
   3. ☐ Yes *Ya* ☐ No *Tidak*

JOB SKILLS *KEMAHIRAN PEKERJAAN*

4. What is the qualification needed for the job?
   Kelulusan yang diperlukan dalam pekerjaan anda?
   4. _____
5. Any special skills required?
   Adakah kemahiran khas diperlukan?
   5. _____
6. What level of practical experience is required?
   Apakah tahap pengalaman praktikal yang diperlukan?
   6. _____

G. TRAVEL & BUSINESS HOURS *PERJALANAN KE TEMPAT KERJA DAN WAKTU BEKERJA*

1. What is your normal working hours and days?
   Apakah waktu dan hari bekerja yang biasa?
   1. _____
2. Are you required to work on shift, Sunday or on-call?
   Adakah anda diperlukan bekerja syif, pada hari Ahad atau bila dipanggil?
   2. _____
3. How do you go to work?
   Bagaimanakah anda pergi ke tempat kerja?
   3. _____
4. What is the distance of travel to go to your normal place of work?
   Jarak perjalanan ke tempat kerja anda?
   4. _____
5. Does your work require you to: *Adakah pekerjaan anda memerlukan anda untuk:*
   - ☐ Driving a car *Memandu kereta*
   - ☐ Driving other vehicles *Memandu kenderaan lain*
   - ☐ Climbing ladders or heights *Memanjat tangga atau tempat tinggi*
   - ☐ Travelling away from your normal place of work *Keluar dari tempat kerja yang biasa*
   - ☐ Other physical exertions. Please specify. *Lain-lain penggunaan tenaga fizikal. Sila nyatakan.*
   - ☐ Carrying heavy loads *Membawa barangan berat*
   - ☐ Lifting heavy loads *Mengangkat barangan berat*
   - ☐ Crawling or kneeling *Merangkak atau melutut*

_____

H. TO BE COMPLETED BY A SELF-EMPLOYED PERSON ONLY
UNTUK DIISI OLEH ORANG YANG BEKERJA SENDIRI SAHAJA

1. Please name your business/Company *Berikan nama perniagaan/Syarikat anda*	1. _____
2. What is the nature of your business? *Jenis perniagaan anda?*	2. _____
3. Are there any other proprietors or directors of the business? How many? *Adakah terdapat pemilik atau pengarah yang lain di dalam perniagaan ini? Berapa orang?*	3. _____
4. Please provide your business registration number and your Company registration number, if incorporated. *Sila berikan no. pendaftaran perniagaan atau Syarikat, jika didaftarkan.*	4. _____

I. TO BE COMPLETED IF DISABILITY CAUSED BY AN ACCIDENT
UNTUK DIISIKAN JIKA HILANG UPAYA DISEBABKAN OLEH KEMALANGAN

1. When did the accident happen? *Bila kemalangan berikut berlaku?*	1. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)* _____ a.m. / p.m. *pagi / petang*
2. Where did the accident happen? *Di mana kemalangan tersebut berlaku?*	2. _____
3. Describe in detail how the accident happened. *Nyatakan secara terperinci bagaimana kemalangan berlaku*	3. _____
4. Describe the extent of the injuries sustained in the accident. *Nyatakan tahap kecederaan yang dialami akibat kemalangan.*	4. _____

J. TO BE COMPLETED IF DISABILITY CAUSED BY AN ILLNESS
UNTUK DIISIKAN JIKA HILANG UPAYA DISEBABKAN OLEH PENYAKIT

1. Please fully describe the condition or the symptoms. *Nyatakan dengan terperinci keadaan atau tanda-tanda penyakit anda.*	1. _____
2. When did the symptoms/condition first appear? *Bilakah tanda-tanda/keadaan itu mula-mula timbul?*	2. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
3. When did you first consult doctor for the symptoms? *Bilakah anda berjumpa doktor buat pertama kali mengenai tanda-tanda penyakit anda?*	3. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
4. What is the exact diagnosis? *Apakah keputusan diagnosis?*	4. _____
5. When was the diagnosis first made known to you? *Bilakah anda diberitahu megenai diagnosis anda?*	5. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
6. Provide the name and address of the doctor who had made the diagnosis? *Berikan nama dan alamat doktor yang telah membuat diagnosis tersebut?*	6. _____
7. What tests or investigations were done to confirm the diagnosis? *Apakah ujian atau penyiasatan yang telah dibuat untuk mengesahkan diagnosis itu?*	7. _____
8. What are the treatments you undergoing currently? *Apakah rawatan yang diterima sekarang?*	8. _____

9. Were you suffering from any other illness or related conditions prior to the onset of the disability? Please state the illness or condition and the details of treatment (by whom, address and when).
Adakah anda menghidap apa-apa penyakit lain atau keadaan yang berkaitan sebelum hilang upaya bermula? Sila nyatakan penyakit atau keadaan dan butir-butir rawatan (oleh siapa, alamat dan bila).

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, 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 profesional 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. Telefon* _____
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 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* _____

TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT

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 / *Nama Hayat yang Diasuranskan*

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)

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 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 and Address of Clinic / Hospital

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

   (ii) Date(s) of subsequent consultation(s) / follow up(s) (ii) _____

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)

   (v) Date when diagnosis was first made to the Life Assured (v) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

   (vi) What was the exact information conveyed to the Life Assured? (vi) _____

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. (i) Type of investigations / tests done to confirm the diagnosis

(i) _____

(ii) Type of treatments given and his / her response to the treatments.

(ii) _____

7. (i) Life Assured's occupation before disability

(i) _____

(ii) Nature of duties of the occupation in 7 (i)

(ii) _____

(iii) How does the Life Assured's disability prevent him / her from performing the above listed duties of his / her occupation?

(iii) _____

8. Did the Life Assured consult other doctors for this condition or its symptoms BEFORE he / she consulted you?

☐ Yes ☐ No

If "YES", please provide the following:

Name of Doctor	Name of Clinic/Hospital and Address	Date of First Consultation

Question 9 to be completed if disability caused by an accident

9. (i) Is the condition a result of an accident?

(i) ☐ Yes ☐ No

If "YES", please state the date of accident

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) Describe in detail how the accident happened

(ii) _____

(iii) Was the Life Assured under the influence of alcohol / drug at the time of accident?

(iii) ☐ Yes ☐ No

If "YES", please state the blood alcohol content/drug type and quantity consumed.

_____

(iv) Is the condition self-inflicted?

(iv) ☐ Yes ☐ No

If "YES", please provide full details

_____

Please complete the **Question 11 to 20** based on your latest detailed examination at the date in **Question 10.**

10. Last examination / consultation date

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

11. Please describe fully the nature of the Life Assured's disabilities.

_____

_____

12. Vision (Visual Acuity)

	Right	**Left**
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

13. Hearing

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

(Supported by an Audiometry results)

Remarks: _____

14. Function of speech

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Remarks: _____

15. Cognitive function

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

Remarks: _____

16. 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) _____

17. Examination of the Limbs

(i) 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		

Remarks: _____

(ii) Please indicate the Range of Movement of the various joint in the table below.

Upper Limbs	Right	Left
Shoulder		
Elbow		
Wrist		
Finger(s)		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

Remarks: _____

18. 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)			

19. (i) Is Life Assured's disability progressively worsening, stagnant or recovering?	(i) _____
(ii) Is full recovery expected?	(ii) ☐ Yes ☐ No If "YES", please state approximate period taken for full recovery from now. _____ If "NO", please state the extent of recovery and approximate period taken for the stated extent of recovery from now. _____ _____
(iii) Is Life Assured confined to a home, hospital or other institution that provides constant care and medical attention? If "YES", since what date?	(iii) _____ ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
20. (i) Is the Life Assured able to perform all the normal duties of his / her usual occupation?	(i) ☐ Yes ☐ No If "YES", when is he/she expected to return to his/her usual occupation? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(ii) If he / she is unable to return to his/her usual occupation, is he / she able to engage in any other occupation?	(ii) ☐ Yes ☐ No
(a) What types of occupation can he / she be engaged in?	(a) _____
(b) When is he / she expected to engage in these occupations?	(b) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
21. Is the Life Assured physically or mentally incapacitated from ever continuing in any employment?	☐ Yes ☐ No If "YES", when did such disability commence? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
22. Is the Life Assured certified to be Total and Permanent Disabled?	☐ Yes ☐ No
(i) If "YES", when did the Life Assured certified to be Total and Permanent Disabled?	(i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(ii) If the incapacity of the Life Assured cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future?	(ii) ☐ Yes ☐ No If "YES", when is the next review / examination of the condition scheduled? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

23. Please provide us with any other additional information that will enable the Company to assess this claim. Please enclose copies of laboratory test result, if any.

_____

_____

_____

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)