CUEPACS LIVING CARE

RL MAJUSINAR SDN BHD (934287-H)

PEJABAT :
Bangunan PSM, Level 3, No. 17B, Jalan Bangsar, 59200 Kuala Lumpur.
Tel : 03-2283 6364 / 2283 6361, Fax : 03-2283 6272
H/P : 013-340 1277 Email: gs118clc@yahoo.com

Dimaklumkan bahawa untuk tuntutan penyakit kritikal pihak kami memerlukan dokumen berikut untuk proses selanjutnya :-

1) **Borang Accident Claim Form - diisi oleh doktor**
2) **Borang Kenyataan Penuntut - diisi oleh pesakit**
3) **Surat Pemberikuasaan / Kebenaran - diisi oleh pesakit**
4) **Salinan kad pengenalan pesakit.**
5) **Salinan kad pengenalan pembayar (hanya untuk tuntutan pasangan & anak)**
6) **Salinan Employment Termination Letter**
7) **Salinan Employment Letter**
8) **Salinan PERKESO offer Letter and PERKESO "Keputusan Jemaah Doctor"**
9) **Salinan Medical Report for application of PERKESO keilatan**
10) **Salinan EPF Withdrawal Letter**
11) **Salinan Medically Boarded Out Letter from Employer with Medical Report**
12) **Salinan all relevant investigation Test Reports (i.e Radiology)**
13) **Salinan laporan polis (jika berkenaan)**
14) **Salinan keratan akhbar (jika berkenaan)**

PERHATIAN: SEMUA DOKUMEN HENDAKLAH DIAKUI SAH DARIPADA DOKTOR ATAU KETUA UNION

PERMOHONAN HENDAKLAH DIPOSKAN MENGIKUT ALAMAT KAMI DI BANGSAR DAN PERMOHONAN INI TIDAK BOLEH DIFAKSKAN KEPADA KAMI

SEKIAN, TERIMA KASIH

YANG IKHLAS,

AMIRA

NIK NUR AMIRA IZZATY BT NIK GHAZALI
BAHAGIAN PENTADBIRAN
CUEPACS LIVING CARE

AGENSI PEMASARAN & PERKHIDMATAN PELANGGAN
CUEPACS LIVING CARE
D/A **JAMES D.RAVI & ASSOCIATES**
LEVEL 3, BANGUNAN PSM, NO: 17B, JALAN BANGSAR, 59200 KUALA LUMPUR.
TEL: 03-2283 6361, 2283 6364 Fax: 03-2283 6272

TOTAL AND PERMANENT DISABILITY BENEFITS CLAIM FORM - CLAIMANT'S STATEMENT

BORANG TUNTUTAN FAEDAH HILANG UPAYA TOTAL & KEKAL - KENYATAAN PENUNTUT

Great Eastern
A member of the OCBC Group

SECTION A. PARTICULARS OF PERSON SUFFERING FROM THE DISABILITY *BUTIR-BUTIR ORANG YANG HILANG UPAYA*

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 *Nama*

Contact No. *No. Tel.*

1. a) Residential Address *Alamat Rumah*

Postcode *Poskod* Town *Bandar*

Country *Negara*

b) Correspondence Address *Alamat Surat Menyurat*

☐ Please tick if same as Residential Address above
Sila tandakan sekiranya sama dengan Alamat Rumah

Postcode *Poskod* Town *Bandar*

Country *Negara*

2. a) Nationality *Warganegara*

☐ Malaysian *Malaysian* ☐ Non-Malaysian. Please specify: _____ *Bukan Malaysian. Sila nyatakan*

b) Occupation before disability *Pekerjaan sebelum hilang upaya*

c) Nature of work *Jenis kerja*

☐ Office Work *Kerja Pejabat* ☐ Supervisory *Penyeliaan* ☐ Sales *Jualan* ☐ Operating Machine *Pengendalian Mesin* ☐ Factory *Kilang*

☐ Fieldwork *Kerja Lapangan* ☐ Management *Pengurusan* ☐ Others. Please specify : _____ *Lain-lain. Sila nyatakan :*

d) Name, Address and Contact Number of Employer / Business *Nama, Alamat dan No. Tel. Majikan / Syarikat*

Postcode *Poskod* Town *Bandar*

Country *Negara*

Contact No. *No. Tel.*

3. Any other insurance policy with other company? *Adakah anda mempunyai polisi dengan syarikat lain?*

☐ Yes *Ya* ☐ No *Tidak*

If "Yes", please provide details. *Jika "Ya", sila nyatakan butir-butir tersebut.*

Company *Syarikat*	Policy Number *No. Polisi*

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1300-1300 88 Fax: +603 4259 8000
E-mail wecare-my@greateasternlife.com Website: greateasternlife.com

 1562247524

SECTION B. GENERAL INFORMATION *MAKLUMAT UMUM*

1.	Date of Disability *Tarikh Hilang Upaya*	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
2.	Are you currently confined to: *Kini terlantar:*	☐ Bed *Katil* ☐ Wheelchair *Kerusi roda* ☐ Hospital *Hospital*
3.	Last date of work *Tarikh terakhir kerja*	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
4.	Date expected to return to work and daily activities *Tarikh dijangka kembali bekerja dan menjalankan aktiviti harian*	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
5.	Date terminated from employment, if any *Tarikh perkhidmatan ditamatkan, jika ada* *Please enclose letter of termination **Sila lampirkan surat penamatan pekerjaan*	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
6.	Highest level of education *Tahap pendidikan tertinggi*	☐ Primary *Sekolah rendah* ☐ Secondary *Sekolah menengah* ☐ Tertiary *Pengajian tinggi*

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

I. TOTAL AND PERMANENT DISABILITY BENEFITS CLAIM DUE TO ACCIDENT
TUNTUTAN FAEDAH HILANG UPAYA DISEBABKAN OLEH KEMALANGAN

1.	Date & Time of accident *Tarikh & Masa kemalangan*	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)* _____ a.m. / p.m. *pagi / petang*
2.	Exact location of accident *Lokasi sebenar kemalangan*	☐ House *Rumah* ☐ Workplace *Tempat Kerja* ☐ Road/Others, please specify & state the address : *Jalan raya/ Lain-lain, sila tentukan & nyatakan alamat :* _____
3.	How did the accident happen? *Bagaimana kemalangan berlaku?*	☐ Fall *Jatuh* ☐ Industrial Accident *Kemalangan Industri* ☐ Road Traffic Accident *Kemalangan Jalan Raya* ☐ Others. Please specify : *Lain-lain. Sila tentukan :* _____

II. TOTAL AND PERMANENT DISABILITY BENEFITS CLAIM DUE TO ILLNESS
TUNTUTAN FAEDAH HILANG UPAYA DISEBABKAN OLEH PENYAKIT

1.	Name of illness *Nama penyakit*	
2.	What were the complaint(s)/ ailment(s) of the illness? *Apakah tanda-tanda penyakit?*	
3.	When did the complaint(s)/ailment(s) first appear? *Bilakah tanda-tanda penyakit*	(dd/mm/yyyy) *(hh/bb/tttt)*
4.	First visit to doctor? *Kali pertama berjumpa doktor?*	☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*

III. CLAIMS RELATED DETAILS *BUTIR-BUTIR BERKAITAN TUNTUTAN*

1. Details of all doctor(s) or specialist(s) who have been consulted due to these injury(s)/complaint(s)/ailment(s) :-
Butir-butir semua doktor atau pakar yang merawat anda untuk kecederaan/tanda-tanda penyakit anda :-

Name of Doctor or Specialist *Nama Doktor atau Pakar*	Name & Address of Hospital or Clinic *Nama dan Alamat Hospital atau Klinik*	Date of Visit *Tarikh Rawatan*

2. Was there any other illness before this disability?
Pernahkah anda mengalami penyakit lain sebelum ini?
☐ Yes *Ya* ☐ No *Tidak*

If "Yes", please state the other illnesses or conditions. *Jika "Ya", sila nyatakan penyakit atau keadaan lain tersebut.*

Name of Illness *Nama Penyakit*	Name of Doctor or Specialist *Nama Doktor atau Pakar*	Name & Address of Hospital or Clinic *Nama dan Alamat Hospital atau Klinik*	Date of Visit *Tarikh Rawatan*

SECTION D. DECLARATION & AUTHORISATION BY THE LIFE ASSURED / ASSURED (POLICY OWNER) / CLAIMANT FOR ALL APPLICABLE POLICIES

PENGISYTIHARAN & KEBENARAN OLEH HAYAT YANG DIASURANSKAN / ASURED (PEMILIK POLISI) / PIHAK YANG MENUNTUT BAGI SEMUA POLISI BERKAITAN

I declare the above answers are true and correct and I 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 (Policy owner) / Claimant hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic, insurance company, credit reporting agency, 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 employee about my personal data, employment and credit information (as defined in Credit Reporting Agencies Act 2010) in order to process my insurance claim. I authorise the Company and its representative to give and release any such information to any party in relation to my application or transaction with the Company for the following purposes (but not limited to): verifying information given pursuant to this claim,background screening, credit evaluation, scoring solutions, administration, analysis or monitoring of policy with the Company or processing of claim. I, the Life Assured / Assured (Policy owner) / Claimant, expressly waive on behalf of myself or any other 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(Policy owner) / Claimant, hereby authorise and give 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 and/or payment made in excess of any claim amount. I, the Life Assured/Assured (policy owner) / Claimant, hereby authorise and give consent to the Company to amend my addresses as provided in this claim form. This authorisation shall irrevocably bind my successors and assignees and shall remain valid not withstanding my death or incapacity, and a copy of this form shall be effective and valid as the original.

Saya mengisytiharkan bahawa jawapan di atas adalah betul dan benar serta saya bersetuju jika saya membuat atau akan membuat sebarang kenyataan yang tidak tepat atau menahan atau menyembunyikan sebarang fakta material; hak saya/Hayat yang Diasuranskan untuk menerima pampasan akan dilucutkan dengan mutlak. Saya, Hayat yang Diasuranskan / Asured (Pemilik Polisi) / Pihak yang Menuntut dengan ini membenarkan dan memberi kebenaran kepada mana-mana doktor, pengamal perubatan, pakar perubatan, hospital, makmal, pakar bedah, jururawat, kakitangan perubatan, klinik, syarikat insurans, agensi pelaporan kredit, organisasi, institusi atau individu yang mungkin mempunyai sebarang rekod atau pengetahuan berkenaan kesihatan atau sejarah kesihatan saya / Hayat yang Diasuranskan ("Pemberi Maklumat") bagi menyediakan maklumat tersebut kepada GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("Syarikat") dan penyedia perkhidmatan berdaftar dan/atau pekerjanya mengenai maklumat peribadi saya, pekerjaan dan maklumat kredit (seperti yang ditakrifkan dalam Akta Agensi Pelaporan Kredit 2010) bagi memproses tuntutan insurans saya. Saya memberi kebenaran kepada Syarikat dan wakilnya untuk memberi dan mengeluarkan sebarang maklumat kepada mana-mana pihak mengenai permohonan atau transaksi dengan Syarikat untuk tujuan berikutnya (tetapi tidak terhad kepada) : pengesahan maklumat yang diberikan menurut tuntutan ini, pemeriksaan latar belakang,penilaian kredit, penyelesaian skor, pentadbiran, analisis atau pemantapan polisi dengan Syarikat atau proses tuntutan. Saya, Hayat yang Diasuranskan / Asured (Pemilik Polisi) / Pihak yang Menuntut, bagi pihak saya atau mana-mana individu yang mempunyai sebarang tuntutan atau kepentingan dalam mana-mana polisi di bawah ini, mengetepikan semua peruntukan undang-undang atau etika profesional yang melarang mana-mana Pemberi Maklumat daripada mendedahkan sebarang maklumat yang diperlukan semasa memberi perkhidmatan kepada saya dalam kapasiti sebagai seorang profesional. Saya, Hayat yang Diasuranskan / Asured (Pemilik Polisi) / Pihak yang Menuntut, dengan ini memberi kebenaran dan keizinan untuk menolak wang yang perlu dibayar kepada Syarikat daripada jumlah tuntutan yang boleh dibayar menurut sebarang polisi di bawah ini, termasuk tetapi tidak terhad kepada sebarang Pinjaman Premium Automatik, Pinjaman Tunai, tunggakan faedah, premium yang perlu dibayar, manfaat yang telah didahulukan dan/atau pembayaran salah yang dibuat melebihi sebarang amaun tuntutan. Saya, Hayat yang Diasuranskan / Asured (Pemilik Polisi) / Pihak yang Menuntut, memberi kebenaran dan keizinan kepada Syarikat untuk membuat pindaan maklumat terhadap alamat-alamat saya yang dinyatakan dalam borang tuntutan ini. Kebenaran ini akan terikat kepada pengganti hak milik dan penerima serah hak tanpa boleh ditarik balik serta kekal sah walaupun selepas saya meninggal dunia atau hilang upaya serta salinan borang ini adalah berkuat kuasa dan sah seperti asal.

Authorisation for Claim Matters and Amendment of Address

Kebenaran untuk Perkara-Perkara Tuntutan dan Pindaan Maklumat Alamat

I, the Life Assured/Assured (Policy owner)/Claimant hereby give consent to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("GELM") Agent or Authorised Person, _____ , Agent Code or New NRIC No. _____ to assist in matters pertaining to this claim and cheque collection, if any. I hereby agree to release and discharge GELM from all losses, claims, allegations, suits, proceedings, demands, damages, costs and expenses arising from or in connection to the said collection. I further agree to indemnify GELM and to keep GELM fully indemnified from and against any and all such losses, claims, allegations, suits, proceedings, demands, damages, costs and expenses arising from or in connection to the said collection. For Group Policies, please refer to respective Union/Servicing Agent/ Employer in relations to cheque collection.

Saya, Hayat yang Diasuranskan/Asured (Pemilik Polisi) / Pihak yang Menuntut, dengan ini memberi kebenaran kepada Ejen GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("GELM") atau Pihak yang diberi kuasa _____ , Kod Ejen atau No. KP Baru _____ untuk membantu dalam perkara-perkara berhubungan dengan tuntutan ini dan pengambilan cek, jika ada. Saya dengan ini bersetuju untuk melepaskan GELM dari segala kerugian, tuntutan dan guaman, prosiding, permintaan, ganti rugi, kos dan perbelanjaan yang timbul dari atau berkaitan dengan penerimaan perkara tersebut. Saya selanjutnya bersetuju untuk menanggung kerugian GELM serta memelihara GELM dengan indemniti sepenuhnya dari dan terhadap sebarang dan segala kerugian, tuntutan, tuduhan, guaman, prosiding, permintaan, ganti rugi, kos dan perbelanjaan yang berbangkit dari atau berkaitan dengan penerimaan perkara tersebut.Sila rujuk kepada Kesatuan/Ejen Insurans Berkelompok/Majikan tersebut berhubung dengan pengambilan cek bagi polisi berkelompok.

I, Assured (Policy owner)/Claimant _____ NRIC No. _____ hereby give consent to amend my residential and correspondence addresses stated in this form as follows (please tick ONE box only) :-

Saya, Asured (Pemilik Polisi)/ Pihak yang Menuntut _____ NRIC No. _____ dengan ini memberi kebenaran untuk membuat pindaan maklumat alamat rumah dan alamat surat-menyurat saya seperti di bawah (sila tandakan SATU kotak sahaja) :-

☐ I would like to amend the addresses as stated in this form throughout all applicable policies
Saya ingin membuat pindaan maklumat alamat seperti dinyatakan dalam borang ini untuk semua polisi berkaitan

☐ The addresses stated in this form are for this claim transaction only
Alamat-alamat yang dinyatakan hanyalah untuk transaksi tuntutan ini

SECTION D. DECLARATION & AUTHORISATION BY THE LIFE ASSURED / ASSURED (POLICY OWNER) / CLAIMANT FOR ALL APPLICABLE POLICIES

PENGISYTIHARAN & KEBENARAN OLEH HAYAT YANG DIASURANSKAN / ASURED (PEMILIK POLISI) / PIHAK YANG MENUNTUT BAGI SEMUA POLISI BERKAITAN

Note : If Life Assured/Assured is unable to sign due to disability, the thumbprint has to be witnessed by the attending doctor or our authorised officers at any nearest office

***Nota** : Sekiranya Hayat yang Diasuranskan/Asured tidak dapat menandatangani disebabkan oleh hilang upaya, cap jari perlu disaksikan oleh doktor atau pihak yang diberi kuasa di mana-mana cawangan berdekatan.*

Signature of Life Assured
Tandatangan Hayat yang Diasuranskan

Name : *Nama*

NRIC No : *No. KP Baru*

Date *Tarikh :* / / (dd/mm/yyyy) *(hh/bb/tttt)*

Signature of Assured(Policy owner)/ Claimant
Tandatangan Asured (Pemilik Polisi)/ Pihak yang Menuntut

(**if different from the Life Assured)
(Jika lain daripada Hayat yang Diasuranskan)

Name : *Nama*

NRIC No : *No. KP Baru*

Date *Tarikh :* / / (dd/mm/yyyy) *(hh/bb/tttt)*

Contact No. : *No. Tel.*

Address *Alamat :* _____

_____

Signature of Witness
Tandatangan Saksi

Name : *Nama*

NRIC No : *No. KP Baru*

Date *Tarikh :* / / (dd/mm/yyyy) *(hh/bb/tttt)*

Contact No. : *No. Tel.*

Address *Alamat :* _____

_____

SECTION E. DOCUMENTS TO BE SUBMITTED WITH THIS CLAIM *DOKUMEN UNTUK DISERTAKAN BERSAMA TUNTUTAN INI*

Note

i. **Photocopy of documents MUST be duly certified by authorised parties,** i.e. Claims Officer or Customer Service Officer or Public Notary or Advocate & Solicitor or Justice of Peace or Ketua Balai Polis or District Officer or Medical Officer or Group Sales Manager or Unit Sales Manager. In addition, for claims incurred outside Malaysia (except Singapore), the confirmation of claim event and all other related documents issued by the Foreign Authority must be certified by Malaysian Embassy or Public Notary at the incident country. If you have returned to Malaysia, the documents can be certified by relevant country's Embassy in Malaysia.
Dokumen Salinan perlu diakui sah oleh pihak yang diberi kuasa, *iaitu, Pegawai Tuntutan atau Pegawai Khidmat Pelanggan di cawangan atau Ibu Pejabat atau Notari Awam atau Peguambela dan Peguamcara atau Jaksa Pendamai atau Ketua Balai Polis atau Pegawai Daerah atau Pegawai Perubatan atau Group Sales Manager atau Unit Sales Manager. Bagi tuntutan yang berlaku di luar Malaysia (kecuali Singapura), pengesahan peristiwa tuntutan dan segala dokumen berkaitan yang dikeluarkan oleh Pihak Berkuasa Di Luar Negara perlu diakui sah oleh Kedutaan Besar Malaysia atau Notari Awam di negara kejadian tersebut. Jika anda telah pulang ke Malaysia, dokumen-dokumen tersebut perlu diakui sah oleh Kedutaan Negara berkenaan di Malaysia.*

ii. This list is not exhaustive. The Company may request further document(s) for the purpose of this claim.
Senarai ini tidak muktamad. Pihak Syarikat berkemungkinan meminta dokumen lain bagi tujuan tuntutan ini.

Please tick (✓)the documents submitted.
Sila tandakan dokumen yang disertakan.

CTC = Certified true copy** ***Salinan diakui sah

1. Direct Credit Facility Form (if not submitted before) ☐
   Borang Kemudahan Kredit Terus (jika tidak pernah disertakan)

2. Total and Permanent Disability Benefits Claim
   Tuntutan Faedah Hilang Upaya Total dan Kekal

   a) Total and Permanent Disability Benefits Claim Form- Claimant's Statement ☐
      Borang Tuntutan Faedah Hilang Upaya Total dan Kekal- Kenyataan Penuntut

   b) Total and Permanent Disability Claim- Doctor's Statement ☐
      Tuntutan Faedah Hilang Upaya Total dan Kekal- Kenyataan Doktor

   c) Letter of Authorisation/Consent ☐
      Surat Pemberikuasa/Kebenaran

   d) CTC of Life Assured's NRIC ☐
      Salinan diakui sah Kad Pengenalan Hayat yang Diasuranskan

   e) CTC of Claimant's NRIC (if different from Life Assured) ☐
      Salinan diakui sah Kad Pengenalan Pihak yang Menuntut (Jika lain daripada Hayat yang Diasuranskan)

   f) CTC of Employment Termination Letter ☐
      Salinan diakui sah Surat Penamatan Pekerjaan

   g) CTC of Employment Letter ☐
      Salinan diakui sah Surat Pekerjaan

   h) CTC of PERKESO offer Letter and PERKESO 'Keputusan Jemaah Doktor' ☐
      Salinan diakui sah Surat Tawaran PERKESO dan Keputusan Jemaah Doktor PERKESO

   i) CTC of Medical Report for application of PERKESO Keilatan ☐
      Salinan diakui sah Laporan Perubatan untuk permohonan PERKESO Keilatan

   j) CTC of EPF Withdrawal Letter ☐
      Salinan diakui sah Surat Pengeluaran KWSP

   k) CTC of Medically Boarded Out Letter from Employer with Medical Report ☐
      Salinan diakui sah Surat Penamatan Khidmat Bekerja dari Majikan serta Laporan Perubatan

   l) CTC of all relevant investigation Test Reports ☐
      Salinan diakui sah semua Laporan Ujian Siasatan berkenaan

   m) CTC of Police Report(s) if disability due to an accident, if applicable ☐
      Salinan diakui sah Laporan Polis jika hilang upaya disebabkan oleh kemalangan, jika berkenaan

   n) Copy of Newspaper Cutting(s) if disability due to an accident, if applicable ☐
      Salinan Keratan Akhbar jika hilang upaya disebabkan oleh kemalangan, jika berkenaan

If Life Assured/Assured is Non-Malaysian or if the incident occured outside Malaysia (except Singapore), please attach
Sekiranya Hayat yang Diasuranskan/Asured bukan warganegara Malaysia atau peristiwa berlaku di luar Malaysia(kecuali Singapura), sila lampirkan

CTC of Full Passport Book ☐
Salinan diakui sah Buku Pasport Lengkap

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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

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/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*

GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)
Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1300-1300 88 Fax: +603 4259 8000
Email: wecare-my@greateasternlife.com Website: greateasternlife.com

TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S 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 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 Total and Permanent Disability 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, pre-malignant condition, cancer 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) _____

   (vii) What is the underlying cause of the illness for the diagnosis above? (vii) _____

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1300-1300 88 Fax: +603 4259 8000
E-mail: wecare-my@greateasternlife.com Website: greateasternlife.com

 5952467525

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.

Name: _____

Address:

Signature and Official Stamp

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)