



CUEPACS TAKAFUL LIVING CARE

RL MAJUSINAR PLUS SDN BHD (1265909-V)



Pejabat:

Bangunan PSM, Level 3, No. 17B, Jalan Bangsar, 59200 Kuala Lumpur.
Tel: 03-22836361 / 22836364 Fax: 03-22836272
H/P : 017-6340518 Email : ctlcplus@yahoo.com

KEPADA

TUAN/PUAN,

TUNTUTAN HILANG UPAYA KEKAL
SKIM INSURANS BERKELOMPOK CUEPACS / KOHASIL

Dimaklumkan bahawa untuk tuntutan hilang upaya kekal pihak kami memerlukan dokumen berikut untuk proses selanjutnya :-

1. Borang Tuntutan Takaful
2. Borang Tuntutan Takaful - Pernyataan Doktor bagi tuntutan hilang upaya kekal
3. Borang Tuntutan Takaful - Surat Pemberikuasa/Kebenaran
4. Salinan Kad Pengenalan/ Sijil Kelahiran yang diakui sah(Pencadang,Orang yang dilindungi & Orang yang menuntut)
5. Bukti Documen bagi hubungan keluarga antara Pencadang , Orang yang Dilindungi dan Orang yang menuntut (ch: Sijil Kelahiran/Sijil Perkhawinan)
6. Laporan Perubatan Tambahan (jika ada)
7. Salinan semua Laporan Makmal dan Penyiasatan yang diakui sah (jika ada)
8. Borang Kemudahan Kredit Langsung

**** PERHATIAN: SEMUA DOKUMEN HENDAKLAH DIAKUI SAH DARIPADA DOKTOR @ KETUA UNION**

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

****PIHAK GETB AKAN MEMINTA DOKUMENTASI TAMBAHAN SEKIRANYA MEMERLUKAN MAKLUMAT LAIN.**

SEKIAN, TERIMA KASIH.

TOTAL AND PERMANENT DISABILITY BENEFITS CLAIM FORM - CLAIMANT'S STATEMENT
BORANG TUNTUTAN FAEDAH HILANG UPAYA PENUH & KEKAL - KENYATAAN PENUNTUT



Certificate No. No. Sijil	<input type="text"/>	New NRIC No. No. KP Baru	<input type="text"/> - <input type="text"/> - <input type="text"/>
Certificate No. No. Sijil	<input type="text"/>	Old NRIC/ Birth Certificate No. KP Lama/ Sijil Kelahiran	<input type="text"/>
Certificate No. No. Sijil	<input type="text"/>	Name of the Person Covered Nama Orang yang Dilindungi	<input type="text"/>
Certificate No. No. Sijil	<input type="text"/>	Contact No. No. Telefon:	<input type="text"/>

SECTION A. PARTICULARS OF THE PERSON COVERED BUTIR-BUTIR ORANG YANG DILINDUNGI

1. Current correspondence address: <i>Alamat surat-menyurat terkini</i>	1. _____	
2. E-mail Address <i>Alamat E-mel:</i>	2. _____	
3. Nationality <i>Warganegara:</i>	3. <input type="checkbox"/> Malaysian <i>Malaysia</i> <input type="checkbox"/> Non-Malaysian. Please specify: <i>Bukan Malaysia. Sila nyatakan</i> _____ Passport No. <i>No. Pasport:</i> _____ Passport Expiry Date <i>Tarikh Luput Pasport:</i> _____ (dd/mm/yyyy) (hh/bb/tttt)	
4. Occupation Details <i>Butir-Butir Pekerjaan</i>	Prior to suffering from disability <i>Sebelum hilang upaya keseluruhan kekal</i>	Current employment status <i>Pekerjaan Sekarang</i>
(a) Occupation <i>Pekerjaan:</i>	(a) _____	(a) _____
(b) The Details of the Employer/ Institute/ School (if student) <i>Butir-butir Majikan/ Institusi/ Sekolah (jika pelajar)</i>	(b) _____	(b) _____
i) Contact No. <i>No. Telefon:</i>	(i) _____	(i) _____
(c) Nature of Work <i>Jenis Kerja:</i>	(c) <input type="checkbox"/> Administrative/ Management/ Executive <i>Pentadbiran/ Pengurusan/ Eksekutif</i> <input type="checkbox"/> Supervisory to the field or Sales (Without engaging in manual work) <i>Penyeliaan Lapangan atau Penjualan (Tidak melibatkan kerja manual)</i> <input type="checkbox"/> Non-heavy manual work but with the use of tools or machinery in course of work <i>Kerja manual tidak berat tetapi melibatkan penggunaan peralatan atau mesin semasa menjalankan tugas</i> <input type="checkbox"/> Heavy manual work and the use of tools/ equipment or machinery in course of duties <i>Kerja manual berat dan melibatkan penggunaan peralatan/ perkakasan atau mesin semasa menjalankan tugas</i>	(c) <input type="checkbox"/> Administrative/ Management/ Executive <i>Pentadbiran/ Pengurusan/ Eksekutif</i> <input type="checkbox"/> Supervisory to the field or Sales (Without engaging in manual work) <i>Penyeliaan Lapangan atau Penjualan (Tidak melibatkan kerja manual)</i> <input type="checkbox"/> Non-heavy manual work but with the use of tools or machinery in course of work <i>Kerja manual tidak berat tetapi melibatkan penggunaan peralatan atau mesin semasa menjalankan tugas</i> <input type="checkbox"/> Heavy manual work and the use of tools/ equipment or machinery in course of duties <i>Kerja manual berat dan melibatkan penggunaan peralatan/ perkakasan atau mesin semasa menjalankan tugas</i>
(d) Please describe in detail the exact duties performed: <i>Sila nyatakan tugas sebenar</i>	(d) _____	(d) _____
e) Does Person Covered work require to: <i>Adakah pekerjaan Orang yang Dilindungi memerlukan:</i>	(e) <input type="checkbox"/> Driving a car <i>Memandu Kereta</i> <input type="checkbox"/> Driving other vehicles <i>Memandu kenderaan lain</i> <input type="checkbox"/> Climbing ladders or heights <i>Memanjat tangga atau tempat tinggi</i> <input type="checkbox"/> Travelling away from your normal work <i>Keluar dari tempat kerja yang biasa</i> <input type="checkbox"/> Carrying heavy load <i>Membawa barangan berat</i> <input type="checkbox"/> Lifting heavy loads <i>Mengangkut barangan berat</i> <input type="checkbox"/> Crawling or kneeling <i>Merangkak atau melutut</i> <input type="checkbox"/> Other physical exertions. Please specify: <i>Lain-lain penggunaan tenaga fizikal. Sila nyatakan:</i> _____	(e) <input type="checkbox"/> Driving a car <i>Memandu Kereta</i> <input type="checkbox"/> Driving other vehicles <i>Memandu kenderaan lain</i> <input type="checkbox"/> Climbing ladders or heights <i>Memanjat tangga atau tempat tinggi</i> <input type="checkbox"/> Travelling away from your normal work <i>Keluar dari tempat kerja yang biasa</i> <input type="checkbox"/> Carrying heavy load <i>Membawa barangan berat</i> <input type="checkbox"/> Lifting heavy loads <i>Mengangkut barangan berat</i> <input type="checkbox"/> Crawling or kneeling <i>Merangkak atau melutut</i> <input type="checkbox"/> Other physical exertions. Please specify: <i>Lain-lain penggunaan tenaga fizikal. Sila nyatakan:</i> _____

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<p>5. Does Person Covered have any certificate with other Takaful Operator/ Insurers? <i>Adakah Orang yang Dilindungi mempunyai sijil dengan Pengendali Takaful/ Syarikat Insurans yang lain?</i> If "Yes", please provide the details. <i>Jika "Ya", sila nyatakan butir-butir tersebut.</i></p>	<p>5. <input type="checkbox"/> Yes <i>Ya</i> <input type="checkbox"/> No <i>Tidak</i></p>						
	<table border="1"> <tr> <td>Certificate No./ Polisi No. <i>No. Sijil/ No. Polisi</i></td> <td>Takaful Operator/ Company <i>Pengendali Takaful/ Syarikat</i></td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	Certificate No./ Polisi No. <i>No. Sijil/ No. Polisi</i>	Takaful Operator/ Company <i>Pengendali Takaful/ Syarikat</i>				
	Certificate No./ Polisi No. <i>No. Sijil/ No. Polisi</i>	Takaful Operator/ Company <i>Pengendali Takaful/ Syarikat</i>					

SECTION B. RECORD OF MEDICAL CONSULTATIONS *REKOD RAWATAN PERUBATAN*

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 kecederaan/ tanda-tanda penyakit:-

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

2. Was there any other illness before this disability?
Pernahkah 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 <i>Nama Penyakit</i>	Name of Doctor or Specialist <i>Nama Doktor atau Pakar</i>	Name and Address of Hospital or Clinic <i>Nama dan Alamat Hospital atau Klinik</i>	Date of Visit <i>Tarikh Rawatan</i>

SECTION C. GENERAL INFORMATION *MAKLUMAT UMUM*

1. Date of Disability
Tarikh Hilang Upaya 1. / / (dd/mm/yyyy) (hh/bb/tttt)

2. Are Person Covered currently confined to:
Adakah Orang yang Dilindungi kini terlanjar:
 Bed *Katil* Wheelchair *Kerusi roda* Hospital *Hospital*
 Able to walk with aids *Boleh berjalan dengan bantuan* Able to walk without aids *Boleh berjalan tanpa bantuan* House *Rumah*

3. Last date of work
Tarikh terakhir kerja 3. / / (dd/mm/yyyy) (hh/bb/tttt)

4. Date expected to return to work and daily activities
Tarikh dijangka kembali bekerja dan menjalankan aktiviti harian 4. / / (dd/mm/yyyy) (hh/bb/tttt)

5. Date terminated from employment, if any
Tarikh perkhidmatan ditamatkan, jika ada 5. / / (dd/mm/yyyy) (hh/bb/tttt)
 *Please enclose letter of termination
**Sila lampirkan surat penamatan pekerjaan*

6. Highest level of education
Tahap pendidikan tertinggi 6. Primary *Sekolah rendah* Secondary *Sekolah menengah* Tertiary *Pengajian tinggi*

7. Are Person Covered medically boarded out (MBO)?
Adakah Orang yang Dilindungi diberhentikan kerja atas alasan kesihatan? 7. Yes, please submit the following:-
Ya, sila berikan:- No *Tidak*
 i) Letter from Employer / SOCSO *Surat daripada Majikan/ Perkeso*
 ii) Medical report for MBO *Laporan perubatan untuk pemberhentian kerja atas alasan kesihatan.*

SECTION D. IF DISABILITY DUE TO ACCIDENT

JIKA HILANG UPAYA AKIBAT KEMALANGAN

<p>1. Date & Time of accident <i>Tarikh & Masa kemalangan</i></p>	<p>1. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) _____ a.m. / p.m. <i>(hh/bb/tttt) pagi / petang</i></p>
<p>2. Exact location of accident <i>Lokasi sebenar kemalangan</i></p>	<p>2. <input type="checkbox"/> House <input type="checkbox"/> Workplace <input type="checkbox"/> Road/ Others, please specify & state the address : <i>Rumah Tempat Kerja Jalan raya/ Lain-lain, sila tentukan & nyatakan alamat :</i></p>
<p>3. How did the accident happen? <i>Bagaimana kemalangan tersebut berlaku?</i></p>	<p>3. <input type="checkbox"/> Fall <input type="checkbox"/> Industrial Accident <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Others. Please specify : <i>Jatuh Kemalangan Industri Kemalangan Jalan Raya Lain-lain. Sila tentukan :</i></p>
<p>4. If due to Road Traffic Accident <i>Jika akibat Kemalangan Jalan Raya</i></p>	<p>4. i) Vehicle involved: <i>Kenderaan terlibat:</i></p> <p><input type="checkbox"/> Car <input type="checkbox"/> Motorcycle <input type="checkbox"/> Others, please specify: _____ <i>Kereta Motosikal Lain-lain, sila nyatakan:</i></p> <p>ii) Are the Person Covered: <i>Adakah Orang yang Dilindungi:</i></p> <p><input type="checkbox"/> Driver/ Rider <input type="checkbox"/> Passenger/ Pillion rider <input type="checkbox"/> Others, please specify: _____ <i>(Pemandu/ (Penumpang/ Pembonceng) Lain-lain, sila nyatakan:</i></p> <p>iii) If Person Covered is driver/ rider, please state:- <i>Jika Orang yang Dilindungi adalah pemandu/ penunggang, sila nyatakan:-</i></p> <p>License's Type/ License's Class _____ <i>Jenis Lesen/ Kelas Lesen</i></p> <p>Validity License (<i>Tempoh Lesen</i>)</p> <p>Starts date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) <i>Tarikh mula: (hh/bb/tttt)</i></p> <p>End date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) <i>Tarikh tamat: (hh/bb/tttt)</i></p> <p>* Please enclose CTC License <i>* Sila lampirkan salinan lesen yang disahkan</i></p>
<p>5. Please advice which part of the body was injured and describe the extent of the injuries sustained by the accident <i>Sila nyatakan bahagian badan yang tercedera dan tahap kecederaan yang dialami akibat kemalangan</i></p>	<p>5. _____</p>

SECTION E. IF DISABILITY DUE TO ILLNESS

JIKA HILANG UPAYA AKIBAT PENYAKIT

<p>1. Name of illness <i>Nama penyakit</i></p>	<p>1. _____</p>
<p>2. Brief description of symptom(s)/ complaint(s) <i>Nyatakan secara ringkas tanda-tanda penyakit</i></p>	<p>2. _____</p>
<p>3. Date of the symptom(s) first onset <i>Tarikh tanda-tanda itu mula timbul</i></p>	<p>3. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) (hh/bb/tttt)</p>
<p>4. First visit to doctor <i>Kali pertama berjumpa doctor</i></p>	<p>4. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) (hh/bb/tttt)</p>
<p>5. Date of diagnosis <i>Tarikh diagnosis</i></p>	<p>5. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) (hh/bb/tttt)</p>
<p>6. Name and address of the doctor who had made the diagnosis <i>Nama dan alamat doktor yang membuat diagnosis tersebut</i></p>	<p>6. _____</p>

SECTION G. DECLARATION & AUTHORISATION, AUTHORISATION FOR CLAIM MATTERS AND AMENDMENT OF ADDRESS, DATA PROTECTION NOTICE AND DECLARATION & AUTHORISATION FOR ONLINE SUBMISSION FORM
PENGISYTIHARAN & KEBENARAN, KEBENARAN UNTUK PERKARA-PERKARA TUNTUTAN DAN PINDAAN MAKLUMAT ALAMAT, NOTIS PERLINDUNGAN DATA DAN PENGISYTIHARAN & KEBENARAN UNTUK PENYERAHAN BORANG DI ATAS TALIAN

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/ Person Covered's right to be compensated shall be absolutely forfeited. I, the Person Covered/ Certificate Owner/ Claimant hereby authorize and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic, takaful operator or insurance company, credit reporting agency, organization, institutions or persons that may have any records or knowledge of my / Person Covered's health or medical history ("Information Provider"), to provide such information to GETB and its authorized 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 takaful 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 certificate with the Company or processing of claim. I, the Person Covered/ Certificate Owner/ Claimant, expressly waive on behalf of myself or any other person who shall have any claim or interest in any certificate 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.

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/ Orang yang Dilindungi untuk menerima pampasan akan dilucutkan dengan mutlak. Saya, Orang yang Dilindungi/ Pemilik Sijil/ 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, Pengendali Takaful atau syarikat insurans, agensi pelaporan kredit, organisasi, institusi atau individu yang mungkin mempunyai sebarang rekod atau pengetahuan berkenaan kesihatan atau sejarah kesihatan saya/ Orang yang Dilindungi ("Pemberi Maklumat") bagi menyediakan maklumat tersebut kepada GETB dan penyedia perkhidmatan berdaftar dan/ atau pkerjanya bagi memproses maklumat data peribadi, pekerjaan, dan maklumat kredit saya (seperti yang ditakrifkan dalam Akta 2010 Agensi Pelaporan Kredit (APK) bagi memproses tuntutan Takaful saya. Saya memberi kuasa kepada Pengendali Takaful dan wakilnya untuk memberi dan mengeluarkan sebarang maklumat kepada mana-mana pihak yang berkaitan dengan permohonan saya atau transaksi dengan Syarikat untuk tujuan berikut (tetapi tidak terhad kepada): mengesahkan maklumat yang diberikan berdasarkan tuntutan ini, pemeriksaan latar belakang, penilaian kredit, penyelesaian pemarkahan, pentadbiran, analisis atau pemantauan sijil dengan Syarikat atau pemrosesan tuntutan. Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut, bagi pihak saya atau mana-mana individu yang mempunyai sebarang tuntutan atau kepentingan dalam mana-mana sijil 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.

I, the Person Covered/ Certificate Owner/ Claimant, hereby authorise and give my consent, to the deduction of monies due to the Company from the claim proceeds payable pursuant to any certificate hereunder, including but not limited to any Advance Contribution Account (ACA), contribution due, advance benefit paid, and/ or erroneous or payment made in excess of any claim amount. I, the Person Covered/ Certificate Owner/ Claimant, hereby authorised 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 notwithstanding my death or incapacity, and a copy of this form shall be effective and valid as the original. I, the Person Covered/ Certificate Owner/ Claimant agree that the personal data provided in this form may be used, recorded, stored, archived, disclosed or otherwise processed by the Takaful Operator for the purposes relating to the payment of funds in accordance with my/ our instruction herein, and for the purposes of compliance with any legal or regulatory requirements. I consent that my personal information may be used, recorded, stored, archived, disclosed or otherwise processed by or on behalf of the Takaful Operator (and its successors in title) for the provision of takaful services.

Saya, Orang yang Dilindungi/ Pemilik Sijil/ 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 Sijil di bawah ini, termasuk tetapi tidak terhad kepada sebarang Akaun Sumbangan Pendahuluan, caruman yang perlu dibayar, manfaat yang telah didahulukan dan/ atau pembayaran salah yang dibuat melebihi sebarang amaun tuntutan. Saya, Orang yang Dilindungi/ Pemilik Sijil/ 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 pemegang 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 salinan asal. Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut setuju bahawa data peribadi yang diberi di dalam borang ini mungkin digunakan, direkodkan, disimpan, diarkibkan, dizahirkan atau diproses oleh Pengendali Takaful untuk tujuan berkaitan pembayaran dana sesuai dengan arahan saya/ kami di sini dan untuk tujuan pematuhan sebarang keperluan undang-undang atau peraturan. Saya setuju bahawa maklumat peribadi saya mungkin digunakan, direkodkan, disimpan, diarkibkan, dizahirkan atau diproses oleh atau bagi pihak Pengendali Takaful (dan pengganti hak miliknya) untuk penyediaan perkhidmatan takaful.

Authorisation for Claim Matters and Amendment of Address
Kebenaran untuk Perkara-Perkara Tuntutan dan Pindaan Maklumat Alamat

I, the Person Covered/ Certificate Owner/ Claimant hereby give consent to, GREAT EASTERN TAKAFUL BERHAD (916257-H) ("GETB") 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 GETB 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 GETB and to keep GETB 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.

Saya, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut, dengan ini memberi kebenaran kepada Ejen GREAT EASTERN TAKAFUL BERHAD (916257-H) ("GETB") 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 GETB dari segala kerugian, tuntutan, tuduhan, guaman, prosiding, permintaan, ganti rugi, kos dan perbelanjaan yang berbangkit dari atau berkaitan dengan pengambilan perkara tersebut. Saya selanjutnya bersetuju untuk menanggung kerugian GETB serta memelihara GETB dengan indemniti sepenuhnya dari atau berkaitan sebarang dan segala kerugian, tuntutan, tuduhan, guaman, prosiding, permintaan, ganti rugi, kos dan perbelanjaan yang berbangkit dari atau berkaitan dengan pengambilan perkara tersebut.

I, the Person Covered/ Certificate 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, Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut _____

No. K.P. _____ 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 certificates
Saya ingin membuat pindaan alamat seperti dinyatakan dalam borang ini untuk semua sijil berkaitan
- The addresses stated in this form are for this claim transaction only
Alamat-alamat yang dinyatakan hanyalah untuk transaksi tuntutan ini sahaja

Data Protection Notice

Notis Perlindungan Data

If you have any inquiry such as limiting the processing of certain information, including the withdrawal of consent to the processing of personal information, you may contact our Customer Careline at 1300-13-8338, or write to the Takaful Operator at i-greatcare@greateastertakaful.com.
Sekiranya anda mempunyai sebarang pertanyaan seperti menghadkan pemprosesan maklumat tertentu, termasuk membatalkan persetujuan untuk pemprosesan maklumat peribadi, anda boleh menghubungi talian Careline kami di 1300-13-8338, atau menulis kepada Pengendali Takaful di i-greatcare@greateastertakaful.com.

If you have any complaints in respect of your personal information, you may contact our Privacy Officer at 603-4259 8381.

Sekiranya anda mempunyai sebarang aduan berhubung dengan maklumat peribadi anda, anda boleh menghubungi Pegawai Privasi kami di 603-4259 8381.

For more information on how the Takaful Operator processes your personal information, please log on to our website greateastertakaful.com and read the Client Charter and Privacy Policy.

Untuk keterangan lanjut mengenai cara Pengendali Takaful memproses maklumat peribadi anda, sila layari laman sesawang kami greateastertakaful.com dan baca Piagam Pelanggan dan Dasar Privasi.

Declaration & Authorisation for Online Submission Form

Pengisytiharan & Kebenaran untuk Penyerahan Borang di atas talian

I agree that a copy of documents submitted shall be valid as the original documents and I confirm that the information given on this online submission form is to the best of my knowledge and belief, true in every aspect. I understand that the Takaful Operator reserve the rights to verify the documents submitted for the purpose of processing my claims and agree to provide the original and fair copy of the documents to the Takaful Operator whenever requested.

Saya bersetuju bahawa salinan dokumen dikemukakan adalah sah seperti salinan asal dan saya mengesahkan bahawa maklumat yang diberi melalui penyerahan borang di atas talian adalah yang terbaik dari pengetahuan dan kepercayaan saya, benar dari segala aspek. Saya faham bahawa Pengendali Takaful berhak untuk mengesahkan dokumen untuk tujuan pemprosesan tuntutan saya dan bersetuju untuk memberi salinan asal dan salinan yang adil kepada Pengendali Takaful apabila diminta.

I understand that the making of a fraudulent claim by providing untrue or false information is a criminal offence likely to lead to prosecution. Further, I understand and agree that the Takaful Operator shall have the absolute right to recover the claim amount in full from me if there is any untrue or inaccurate representation on the information provided or submission of tampered or false or untrue information had been submitted for the claim.

Saya faham bahawa membuat penipuan tuntutan dengan mengemukakan maklumat tidak benar atau salah adalah kesalahan jenayah berkemungkinan membawa kepada pendakwaan. Selanjutnya, saya faham dan bersetuju bahawa Pengendali Takaful mempunyai hak mutlak meminta jumlah tuntutan sepenuhnya daripada saya jika terdapat sebarang maklumat yang diberikan adalah tidak benar atau tidak tepat atau penyerahan maklumat yang diusik atau maklumat yang dikemukakan adalah salah atau tidak benar untuk tuntutan.

NOTE: If Person Covered/ Certificate Owner/ Claimant 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 Orang yang Dilindungi/ Pemilik Sijil/ Pihak yang Menuntut tidak dapat menandatangani disebabkan oleh hilang upaya, cap ibu jari perlu disaksikan oleh doktor atau pihak yang diberi kuasa di mana-mana cawangan berdekatan.

Signature of Person Covered
Tandatangan Orang yang Dilindungi

Name *Nama:* _____

NRIC No./ Passport No.: _____
No. KP Baru/ No. Passport

Date *Tarikh:* _____

Signature of Certificate Owner/ Claimant
Tandatangan Pemilik Sijil/ Pihak yang Menuntut
If different from the Person Covered
(Jika lain daripada Orang yang Dilindungi)

Name *Nama:* _____

NRIC No./ Passport No.: _____
No. KP Baru/ No. Passport

Contact No. *No. Telefon:* _____

Address *Alamat:* _____

Email *Emel:* _____

Date *Tarikh:* _____

Relationship with the
Person Covered: _____

*Hubungan dengan Orang
yang Dilindungi*

Signature of Witness
Tandatangan Saksi

Name *Nama:* _____

NRIC No./ Passport No.: _____
No. KP Baru/ No. Passport

Contact No. *No. Telefon:* _____

Address *Alamat:* _____

Email *Emel:* _____

Date *Tarikh:* _____

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LETTER OF AUTHORISATION/CONSENT - To Obtain Further Information
SURAT PEMBERIKUASA/KEBENARAN - Untuk Mendapatkan Maklumat Lanjut



Certificate No. <i>No. Sijil</i>	<input type="text"/>	New NRIC No. <i>No. KP Baru</i>	<input type="text"/> - <input type="text"/> - <input type="text"/>
Certificate No. <i>No. Sijil</i>	<input type="text"/>	Old NRIC/BC/Passport No. <i>No. KP Lama/Sijil Kelahiran/ Pasport</i>	<input type="text"/>
Certificate No. <i>No. Sijil</i>	<input type="text"/>	Name of Person Covered <i>Nama Orang yang Dilindungi</i>	<input type="text"/>
Certificate No. <i>No. Sijil</i>	<input type="text"/>		

Our Ref: _____
Rujukan Kami:

To Whom It May Concern
Kepada Sesiapa Yang Berkenaan

Dear Sir/Madam,
Tuan/Puan,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, takaful operator, or *Saya dengan ini memberi kuasa dan mengizinkan mana-mana pegawai perubatan, doktor, pakar bedah, klinik, hospital, pusat perubatan, pengendali takaful atau* other organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of *organisasi, institut atau orang perseorangan ("Pemberi Maklumat") yang mungkin mempunyai apa-apa rekod atau mengetahui tentang pekerjaan,* the employment, financial, health or medical history of _____
kewangan, kesihatan atau sejarah perubatan

("the Certificate Owner") and to provide such information to GREAT EASTERN TAKAFUL BERHAD (916257-H) ("the Takaful Operator") or *("Pemilik Sijil") untuk memberi maklumat kepada GREAT EASTERN TAKAFUL BERHAD (916257-H) ("Pengendali Takaful") atau*

its authorised agents and/or employees.
mana-mana ejen/kakitangannya yang diberi kuasa.

I expressly waive on behalf of myself and/or as a next-of-kin of the Certificate Owner and for his/her estate all provisions of law or professional *Saya juga tidak ragu-ragu untuk mengetepikan bagi pihak saya dan/atau sebagai waris terdekat Pemilik Sijil dan untuk harta pusakanya segala peruntukan* ethics forbidding the Information Provider(s) from disclosing any such information acquired on the Certificate Owner in a professional and/or client *undang-undang atau etika profesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai Pemilik Sijil dalam bidang kuasa* capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may arise, in supplying such *sebagai profesional dan/atau pelanggan dan saya juga memberi pelepasan kepada Pemberi Maklumat ejen/kakitangannya daripada apa-apa liabiliti kerana memberi* information requested by the Takaful Operator.
maklumat tersebut kepada Pengendali Takaful.

This authorisation/consent is irrevocable and a copy of it will have the same effect and validity as the original.
Surat pemberikuasa/kebenaran ini adalah muktamad dan salinannya juga memberi hak dan pengesahan yang sama dengan yang asal.

Signature or Thumb Print _____
Tandatangan atau Cap Ibu Jari

Name _____
Nama

NRIC No _____ Date _____
No KP Tarikh

Relationship with the Certificate Owner _____
Hubungan dengan Pemilik Sijil

Registration or Admission No. (If hospitalised) _____
Pendaftaran atau No. Kemasukan. (Jika masuk hospital)

CLM-GLOAC-V06-082025-TAKAFUL

Requirement Checklist for Family Claims Submission



Dear Members of Field Force,

You are advised to use this checklist as a guide on the documents required for the claim filed. You may obtain a copy of this checklist from Agent Service Centre, Form Counter or Servicing Branch and i-Greatpartner.

Important Notes :

1. Please ensure that these requirements are fully complied with in order for us to assess the claim without delay.
2. **Group Manager (GM) or Unit Manager (UM) may certified all claims documents with the exception of claims incurred outside of Malaysia where the confirmation of the claim event and all other related and relevant documents issued by the Foreign Authority must be certified by the Malaysian Embassy or a Public Notary. Full passport book is required for all foreign claims.**
Please ensure that at all times, all certified copies of the claim document are duly signed and stamped with the name and rank of the GM or UM.
3. **Submit this Requirement Checklist with the claim submission and tick the checkbox for documents submitted.**
4. **The Takaful Operator may request for additional documents/reports if deemed necessary.**

Certificate No. :	_____	Branch :	_____	Agent's signature :	_____
Participant/Person Covered :	_____	Agent/Contact No. :	_____	Date :	_____

Direct Credit

- Direct Credit Facility Form
- Copy of NRIC
- Copy of bank statement / first page of bank passbook with account details

Death Claims

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Death Claim Form - Claimant's Statement <input type="checkbox"/> CTC Death Certificate <input type="checkbox"/> CTC Claimant's NRIC <input type="checkbox"/> CTC Deceased's NRIC <input type="checkbox"/> CTC of Embarkment Certificate <input type="checkbox"/> CTC Marriage Certificate if Claimant is spouse <input type="checkbox"/> CTC Birth Certificate of Claimant if Claimant is child <input type="checkbox"/> CTC Birth Certificate of Deceased if Claimant is parent <input type="checkbox"/> Original copy of Letter of Authorisation/Consent (3 copies) <input type="checkbox"/> Confirmation letter from National Registration Department (for overseas death claims) <p><u>Additional requirements on accidental death</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Accidental Death Benefit (ADB) Claim Form <input type="checkbox"/> CTC Police Report <input type="checkbox"/> CTC Detailed Post Mortem Report <input type="checkbox"/> CTC of Toxicology Report, if any <input type="checkbox"/> Newspaper Cutting, if any <input type="checkbox"/> Others : _____ | <p><u>Important Notes</u></p> <ol style="list-style-type: none"> i. If cause of death is unknown, the Takaful Operator will advise further on receipt of the Death Certificate. ii. For foreign Death Claim, CTC full passport book / Citizenship Certificate are required. <p><u>Death due to natural causes</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Doctor's Statement (for policy less than 5 years from date of commencement or from date of reinstatement, whichever is the later) |
|---|--|

Total & Permanent Disability Claims

- TPD Claim Form - Claimant's Statement
- TPD Claim Form - Doctor's Statement
- Original copy of Letter of Authorisation/Consent (3 copies)
- CTC Employment Termination Letter, if applicable
- CTC Person Covered's NRIC
- CTC Claimant's NRIC (if different from Person Covered)
- CTC Clinic/Hospital Consultation Card
- CTC EPF Withdrawal letter, if applicable
- CTC SOCSO Offer Letter/ SOCSO "Keputusan Jemaah Doktor Mengenai Keilatan", if applicable
- CTC of all relevant diagnostic test results or reports
- CTC Police Report (**accidental cause**)
- Newspaper Cutting (**accidental cause**), if applicable
- Others : _____

Accident Rider Claims

- Accident Claim Form - Claimant's Statement
- Accident Claim Form - Attending Physician's Statement
- CTC Person Covered's NRIC
- CTC Claimant's NRIC (if different from Person Covered)
- Original/CTC Medical Certificates
- CTC Police Report, if applicable
- CTC Hospital bill(s) and Payment Receipt(s)
- Original Bills and original Payment Receipts (applicable to reimbursement claims)
- CTC of X-ray, MRI, CT scan or other radiology reports
- Others : _____

Critical Illness Claims

- Critical Illness Claim Form - Claimant's Statement
- Confidential Medical Certificate (Cancer)
- Confidential Medical Certificate (Brain, Nerve & Muscle related condition) - to be completed by Consultant Neurologist
- Confidential Medical Certificate (Heart related conditions)
- Confidential Medical Certificate (Other Illnesses)
- Original copy of Letter of Authorisation/Consent (3 copies)
- CTC of Person Covered's NRIC
- CTC Claimant's NRIC (if different from Person Covered)
- CTC of all relevant diagnostic test results or reports for individual Covered Event (please refer to the list of Covered Events on the reverse side)
- Others : _____

For Office Use	
Checked By :	_____
Check Date :	_____

Note : CTC = Certified True Copy

CLM-RCFCF-V04-082025-TAKAFUL

Great Eastern Takaful Berhad 201001032332 (916257-H)

Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
 Telephone: +603 4259 8338 Fax: +603 4259 8808 Customer Service Careline: 1 300 13 8338
 E-mail: i-greatcare@greasterntakaful.com Website: www.greasterntakaful.com

LIST OF COVERED EVENTS AND THE REQUIRED MEDICAL EVIDENCE

- 1. Heart Attack**
 - Cardiac Enzymes Assay results (CK-MB, Troponin T / Troponin I)
 - ECG tracing
 - Echocardiogram / Coronary Angiogram report
 - 2. Stroke**
 - CT Scan / MRI Report of Brain
 - * CMC to be completed by Consultant Neurologist
 - 3. Coronary Artery Disease Requiring Surgery**
 - Coronary Artery By-Pass Surgery Report
 - 4. Cancer**
 - Histopathology Report
 - CT Scan / MRI Reports, if available
 - Bone Marrow Aspiration / Trepine Biopsy Report (Leukemia only)
 - Blood and laboratory test report
 - 5. Kidney Failure**
 - Kidney Dialysis Report / Dialysis Receipts
 - Kidney transplantation report
 - Blood test results
 - * CMC to be completed by Consultant Nephrologist
 - 6. Fulminant Viral Hepatitis**
 - CT Scan Report of Liver
 - Liver Function Test results
 - Abdominal ultrasound
 - Hepatitis viral serology test
 - Any other laboratory or pathology reports
 - 7. Major Organ Transplant**
 - Surgery Report
 - 8. Paralysis / Paraplegia**
 - X-ray/CT Scan/ MRI Reports, if available
 - 9. Multiple Sclerosis**
 - CT Scan & MRI Report of Brain & Spine
 - Nerve conduction study / Evoked potential test
 - * CMC to be completed by Consultant Neurologist
 - 10. Primary Pulmonary Arterial Hypertension**
 - All clinical and laboratory investigation results including cardiac catheterization
 - Echocardiogram report
 - 11. Blindness**
 - Visual Acuity Report on both eyes to be done by an ophthalmologist
 - * CMC to be completed by an Ophthalmologist.
 - 12. Heart Valve Replacement**
 - Heart Valve Surgery Report
 - 13. Loss of Hearing / Deafness**
 - Pure Tone Audiometry Test and Sound Threshold Test results
 - Brainstem Auditory Evoked Response (BAER) report
 - 14. Surgery to Aorta**
 - Aorta Surgery Report
 - 15. Loss of Speech**
 - Laryngoscopy report
 - * CMC to be completed by speech pathologist/therapist
 - 16. Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorder**
 - All relevant investigation results in support of the diagnosis
 - 17. Major Burns**
 - Total Body Surface Area Burn Assessment Report
 - 18. Coma**
 - * CMC to be completed by Consultant Neurologist
 - 19. Terminal Disease**
 - All relevant investigation results in support of the diagnosis
 - 20. Motor Neuron Disease**
 - CT Scan/ MRI report of the Brain and Spine
 - Electromyography (EMG) test results
 - All relevant investigation results in support of the diagnosis
 - * CMC to be completed by Consultant Neurologist
 - 21. HIV Infection due to Blood Transfusion**
 - HIV antibody test by ELISA method on the date of blood transfusion
 - HIV antibody test by ELISA method 3 - 6 months from date transfusion
 - Statement from statutory Health Authority to confirm that the disease was medically acquired.
 - Western Blot test
 - 22. Parkinson's Disease**
 - All relevant investigation results in support of the diagnosis
 - * CMC to be completed by Consultant Neurologist
 - 23. Chronic Liver Disease**
 - Liver Function Test
 - CT Scan of Liver
 - All laboratory, pathology, hepatitis screening, ultrasound & histology reports
 - 24. Chronic Lung Disease**
 - Pulmonary Function Test results
 - Arterial Blood Gas test results
 - FEV 1 Test results
 - Relevant investigation results
 - 25. Major Head Trauma**
 - CT Scan / MRI Report of Brain
 - Surgery report
 - Police report, if any
 - 26. Aplastic Anemia**
 - Bone Marrow Aspiration Report
 - Blood transfusion records
 - Bone Marrow transplant report
 - Full Blood Picture reports
 - 27. Muscular Dystrophy**
 - Lumbar puncture
 - Electromyography (EMG) test results
 - Muscles biopsy
 - All relevant investigation results in support of the diagnosis
 - * CMC to be completed by Consultant Neurologist
 - 28. Benign Brain Tumor**
 - CT Scan / MRI Report of Brain
 - Histopathology Report, if available
 - 29. Encephalitis**
 - CT Scan / MRI Report of Brain
 - * CMC to be completed by Consultant Neurologist
 - 30. Poliomyelitis**
 - Diagnostic test results
 - * CMC to be completed by Consultant Neurologist
 - 31. Brain Surgery**
 - Brain Surgery Report
 - 32. Bacterial Meningitis**
 - CT Scan / MRI Report of Brain & Spine
 - Lumbar puncture test report
 - 33. Other Serious Coronary Artery Disease**
 - Coronary Angiogram Report
 - 34. Apallic Syndrome**
 - CT Scan / MRI Report of Brain
 - * CMC to be completed by Consultant Neurologist
 - 35. AIDS Cover for Medical Staff**
 - HIV antibody test by ELISA method within 5 days of the event/accident
 - HIV antibody test by ELISA method 3 - 6 months from date of blood transfusion.
 - Statement from statutory Health Authority to confirm that the disease was occupationally acquired.
 - Western Blot test
 - 36. Full Blown AIDS**
 - HIV antibody test by ELISA method
 - Western Blot Test
 - CD4 Cell Count
 - All serial Full Blood Picture blood test results
 - Histopathology examination (HPE)/ Biopsy report for Kaposi sarcoma or Malignant lymphoma
 - CT Scan/ MRI of Brain for Progressive multifocal leukoencephalopathy.
 - Chest X-ray report
 - Sputum C & S report
 - Sputum AFB
- * CMC = Confidential Medical Certificate

LIST OF COVERED EVENTS AND THE REQUIRED MEDICAL EVIDENCE FOR CERTIFICATES INCEPTED YEAR 2012 AND ABOVE

1. Heart Attack

- Cardiac Enzymes Assay results (CK-MB, Troponin T / Troponin I)
- ECG tracing
- Echocardiogram / Coronary Angiogram report

2. Stroke

- CT Scan / MRI Report of Brain
- * CMC to be completed by Consultant Neurologist

3. Coronary Artery By-Pass Surgery

- Coronary Artery By-Pass Surgery Report

4. Cancer

- Histopathology Report
- CT Scan / MRI Reports, if available
- Bone Marrow Aspiration / Trepine Biopsy Report (Leukemia only)
- Blood and laboratory test report

5. End Stage Kidney Failure

- Kidney Dialysis Report / Dialysis Receipts
- Kidney transplantation report
- Blood test results
- * CMC to be completed by Consultant Nephrologist

6. Fulminant Viral Hepatitis

- CT Scan Report of Liver
- Liver Function Test results
- Abdominal ultrasound
- Hepatitis viral serology test
- Any other laboratory or pathology reports

7. Major Organ / Bone Marrow Transplant

- Surgery Report

8. Paralysis / Paraplegia

- X-ray/CT Scan/ MRI Reports, if available

9. Multiple Sclerosis

- CT Scan & MRI Report of Brain & Spine
- Nerve conduction study/ Evoked potential test
- * CMC to be completed by Consultant Neurologist

10. Primary Pulmonary Arterial Hypertension

- All clinical and laboratory investigation results including cardiac catheterization
- Echocardiogram report

11. Blindness / Total Loss of Sight

- Visual Acuity Report on both eyes to be done by an ophthalmologist
- * CMC to be completed by an Ophthalmologist.

12. Heart Valve Surgery

- Heart Valve Surgery Report

13. Deafness / Total Loss of Hearing

- Pure Tone Audiometry Test and Sound Threshold Test results
- Brainstem Auditory Evoked Response (BAER) report

14. Surgery to Aorta

- Aorta Surgery Report

15. Loss of Speech

- Laryngoscopy report
- * CMC to be completed by speech pathologist/therapist

* CMC = Confidential Medical Certificate

16. Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorder

- All relevant investigation results in support of the diagnosis

17. Major Burns

- Total Body Surface Area Burn Assessment Report

18. Coma

- * CMC to be completed by Consultant Neurologist

19. Systemic Lupus Erythematosus (SLE) With Lupus Nephritis

- Lupus Erythematosus (LE) cell blood test results
- Anti-DNA Antibodies
- Urine FEME results over past 6 months
- Renal function tests with eGFR results over past 6 months
- Renal biopsy report

20. Motor Neuron Disease

- CT Scan/ MRI report of the Brain and Spine
- Electromyography (EMG) test results
- All relevant investigation results in support of the diagnosis
- * CMC to be completed by Consultant Neurologist

21. HIV Infection due to Blood Transfusion

- HIV antibody test by ELISA method on the date of blood transfusion
- HIV antibody test by ELISA method 3 - 6 months from date transfusion
- Statement from statutory Health Authority to confirm that the disease was medically acquired.
- Western Blot test

22. Parkinson's Disease

- All relevant investigation results in support of the diagnosis
- * CMC to be completed by Consultant Neurologist

23. End Stage Liver Failure

- Liver Function Test
- CT Scan of Liver
- All laboratory, pathology, hepatitis screening, ultrasound & histology reports

24. End Stage Lung Disease

- Pulmonary Function Test results
- Arterial Blood Gas test results
- FEV 1 Test results
- Relevant investigation results

25. Major Head Trauma

- CT Scan / MRI Report of Brain
- Surgery report
- Police report, if any

26. Chronic Aplastic Anemia

- Bone Marrow Aspiration Report
- Blood transfusion records
- Bone Marrow transplant report
- Full Blood Picture reports

27. Muscular Dystrophy

- Lumbar puncture
- Electromyography (EMG) test results
- Muscles biopsy
- All relevant investigation results in support of the diagnosis
- * CMC to be completed by Consultant Neurologist

28. Benign Brain Tumor

- CT Scan / MRI Report of Brain
- Histopathology Report, if available

29. Encephalitis

- CT Scan / MRI Report of Brain
- * CMC to be completed by Consultant Neurologist

30. Severe Cardiomyopathy

- Echocardiographic report
- Cardiac catheterisation report

31. Brain Surgery

- Brain Surgery Report

32. Bacterial Meningitis

- CT Scan / MRI Report of Brain & Spine
- Lumbar puncture test report

33. Other Serious Coronary Artery Disease

- Coronary Angiogram Report

34. Angioplasty And Other Invasive Treatments For Major Coronary Artery Disease

- Coronary angiogram report
- Percutaneous Coronary Intervention (PCI) or Laser treatment report

35. Loss Of Independent Existence

- CT Scan / MRI report
- Ultrasound report
- Surgery report
- Blood test reports

36. Full Blown AIDS

- HIV antibody test by ELISA method
- Western Blot Test
- CD4 Cell Count
- All serial Full Blood Picture blood test results
- Histopathology examination (HPE)/ Biopsy report for Kaposi sarcoma or Malignant lymphoma
- CT Scan/ MRI of Brain for Progressive multifocal leukoencephalopathy.
- Chest X-ray report
- Sputum C & S report
- Sputum AFB

**TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT**



Certificate No.	<input type="text"/>	New NRIC No.	<input type="text"/> - <input type="text"/> - <input type="text"/>
Certificate No.	<input type="text"/>	Old NRIC/Birth Certificate/ Passport No.	<input type="text"/>
Certificate No.	<input type="text"/>		
Certificate No.	<input type="text"/>	Name of Person Covered	<input type="text"/>

The above name is covered with GREAT EASTERN TAKAFUL 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 Person Covered's usual medical attendant? Yes No
If "YES", since what date? / / (dd/mm/yyyy)

2. Has the Person Covered 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. (i) Date when Person Covered 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 Person Covered had been experiencing these symptoms.

Symptoms	Date symptoms first presented (dd/mm/yyyy)
(a) <input type="text"/>	<input type="text"/>
(b) <input type="text"/>	<input type="text"/>

What is the source of this information?

- Person Covered
 Referring doctor

Name of doctor and hospital / clinic:

Others, please specify:

5. Diagnosis

(i) Please describe the full and exact diagnosis.	(i) <input type="text"/>
(ii) Date when the illness was FIRST diagnosed	(ii) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
(iii) Diagnosis was FIRST made by (name of doctor and hospital)	(iii) <input type="text"/>
(iv) Date when Person Covered FIRST became aware of the illness.	(iv) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
(v) Date when diagnosis was first made to the Person Covered.	(v) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
(vi) What was the exact information conveyed to the Person Covered?	(vi) <input type="text"/>
(vii) What is the underlying cause of the illness for the diagnosis above?	(vii) <input type="text"/>

CLM-TPDDS-V06-082025-TAKAFUL

Great Eastern Takaful Berhad 201001032332 (916257-H)

Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Telephone: +603 4259 8338 Fax: +603 4259 8808 Customer Service Careline: 1 300 13 8338
E-mail: i-greatcare@greatasterntakaful.com Website: www.greatasterntakaful.com

6. (i) Type of investigations / tests done to confirm the diagnosis (ii) Type of treatments given and his / her response to the treatments.	(i) _____ _____ (ii) _____ _____
7. (i) Person Covered's occupation before disability (ii) Nature of duties of the occupation in 7 (i) (iii) How does the Person Covered's disability prevent him / her from performing the above listed duties of his / her occupation?	(i) _____ _____ (ii) _____ _____ (iii) _____ _____

8. Did the Person Covered 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? (ii) Describe in detail how the accident happened (iii) Was the Person Covered under the influence of alcohol / drug at the time of accident? (iv) Is the condition self-inflicted?	(i) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please state the date of accident [] [] / [] [] / [] [] [] [] (dd/mm/yyyy) (ii) _____ _____ (iii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please state the blood alcohol content/drug type and quantity consumed. _____ (iv) <input type="checkbox"/> Yes <input type="checkbox"/> 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 Person Covered'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)			

<p>19. (i) Is Person Covered's disability progressively worsening, stagnant or recovering? (ii) Is full recovery expected?</p> <p>(iii) Is Person Covered confined to a home, hospital or other institution that provides constant care and medical attention? If "YES", since what date?</p>	<p>(i) _____</p> <p>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> 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. _____ _____</p> <p>(iii) _____ _____ _____ (dd/mm/yyyy)</p>
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<p>20. (i) Is the Person Covered able to perform all the normal duties of his / her usual occupation?</p> <p>(ii) If he / she is unable to return to his/her usual occupation, is he / she able to engage in any other occupation? (a) What types of occupation can he / she be engaged in? (b) When is he / she expected to engage in these occupations?</p>	<p>(i) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", when is he/she expected to return to his/her usual occupation? _____/_____/_____ (dd/mm/yyyy)</p> <p>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> No (a) _____ (b) ____/____/_____ (dd/mm/yyyy)</p>
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<p>21. Is the Person Covered physically or mentally incapacitated from ever continuing in any employment?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", when did such disability commence? _____/_____/_____ (dd/mm/yyyy)</p>
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<p>22. Is the Person Covered certified to be Total and Permanent Disabled? (i) If "YES", when did the Person Covered certified to be Total and Permanent Disabled? (ii) If the incapacity of the Person Covered cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (i) ____/____/_____ (dd/mm/yyyy) (ii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", when is the next review / examination of the condition scheduled? _____/_____/_____ (dd/mm/yyyy)</p>
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23. Please provide us with any other additional information that will enable the Takaful Operator 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 Person Covered and that I have answered the above questions are true and to the best of my knowledge and belief.

Name: _____

Signature and Official Stamp

Address: _____

Date: ____/____/_____ (dd/mm/yyyy)