CLAIM FORM FOR GROUP HOSPITALISATION & SURGICAL BENEFIT
BORANG TUNTUTAN RAWATAN HOSPITAL & PEMBEDAHAN POLISI BERKELOMPOK

Great Eastern
A member of the OCBC Group

Policy No. *No. Polisi*
Policy No. *No. Polisi*
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Policy No. *No. Polisi*

New NRIC No. *No. KP Baru* ____ - ____ - ____
Old NRIC/BC/Passport No. *No. KP Lama/Sijil Kelahiran/Paspot*
Name of Life Assured *Nama Hayat yang Diasuranskan*

Instruction - Supporting documents required. Please attach the final original bills and original receipts covering hospitalisation/surgical expenses and completed original Attending Physician Statement.
Arahan - Dokumen sokongan yang diperlukan. Bil asal muktamad terperinci asal dan resit rasmi yang mencatatkan perbelanjaan rawatan hospital dan pembedahan.

1. Name of Employer *Nama Majikan*
   Group Policy No *No Polisi Berkelompok*

2. Employee's Details *Butir-Butir Pekerja*
   a. Name of Employee *Nama Pekerja*
   b. NRIC No *No Kad Pengenalan*
   c. Employee Plan Type *Jenis Pelan Pekerja*
   d. Staff No *No Pekerja*
   e. Date Joined Company *Tarikh Kemasukan Syarikat*
   f. Current Correspondence Address *Alamat Surat Menyurat*
   g. Telephone No *No Telefon*
   h. If The Patient Is A Dependant *Jika Pesakit Adalah Tanggungan Pekerja*
      i) Name of Dependent *Nama Tanggungan*
      ii) Relationship to Employee *Hubungan Dengan Pekerja*
      iii) Name of Dependent's Employer *Nama Majikan Kepada Tanggungan*

3. Statement of Patient *Butir-Butir Pesakit*
   a. NRIC No *No Kad Pengenalan*
   b. Occupation *Pekerjaan*
   c. Date of Birth *Tarikh Lahir*
   d. Name of Hospital *Nama Hospital*
   e. Date Admitted *Tarikh Kemasukan*
   f. Date Discharged *Tarikh Keluar*
   g. Date(s) of Surgery *Tarikh Pembedahan*
   h. Have you claimed before under this Group Policy? *Pernahkah anda membuat tuntutan di bawah polisi berkelompok sebelum ini?* ☐ Yes *Ya* ☐ No *Tidak*
      i) If "Yes", please state date: *Jika "Ya" sila nyatakan tarikh*

4. a. Nature of injury or illness *Kecederaan atau penyakit yang dihidapi*
   b. How did the disability arise? *Bagaimanakah ketidakupayaan ini berlaku?* ☐ Accident *Kemalangan* ☐ Sickness *Penyakit* ☐ Pregnancy *Mengandung*

5. If hospitalisation was due to accident, please furnish details of accident *Jika kemasukan ke hospital akibat kemalangan, sila kemukakan butiran berikut:*
   a. When did it occur? *Bila kemalangan tersebut berlaku?* dd *hh* ____ mm *bb* ____ yy *tt* ____ at *pada* ____ am/pm *pagi /petang*
   b. Where did it occur? *Di mana kemalangan tersebut berlaku?*
   c. How did it occur? *Bagaimana kemalangan tersebut berlaku?*
   d. Nature and extent of injury *Jenis dan tahap kecederaan yang dialami*

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
HealthCare Services Department, Level 16, Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur

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6.	If hospitalisation was due to other causes, please furnish details *Jika kemasukan ke hospital akibat sebab lain, sila kemukakan butiran berikut:*		
	a. Nature of illness/symptom *Jenis penyakit/simtom*		
	b. For how long had you/the life insured been having the symptom prior to first admission? *Berapa lamakah anda/hayat dilindungi telah mengidap simtom yang dikemukan sebelum dimasukan ke hospital?*		
	c. What was the diagnosis? *Apakah diagnosis ketika itu?*		
7.	Name and address of doctors who treated you/the life insured for this illness/injury/condition. *Nama dan alamat doktor yang merawat anda/hayat yang dilindungi untuk penyakit/kecederaan/keadaan ini.*	Date of Consultation *Tarikh Rawatan*	Date of Admission (if any) *Tarikh Kemasukan (jika ada)*
	Doctor's Name *Nama doktor*		
	Address *Alamat*		
8.	Please furnish name and address of your/the life insured's usual attending doctor other than above. *Sila nyatakan nama dan alamat doktor yang selalu merawat anda/hayat yang dilindungi, selain daripada yang atas.*	Doctor's Name *Nama doktor*	Address *Alamat*
9.	Are you/is life insured presently insured for Hospitalisation & Surgical benefits under any government law/program, employee benefit, any health benefit scheme or any other insurance policy? If so, please furnish details. *Adakah anda/hayat yang dilindungi ketika ini dibawah perlindungan insurans faedah Hospital & Pembedahan, di bawah sebarang program/undang-undang kerajaan, kemudahan pekerja, sebarang skim faedah kesihatan atau sebarang polisi insurans lain? Jika ada, sila kemukakan butiran berikut:*		
	a. Name of Company/Program/Scheme *Nama Syarikat/Program/Skim*		
	b. Policy/Membership No *No Polisi/Keahlian*		

10. Authorization ***Kebenaran/Pemberian Hak***

I _____ NRIC No _____ hereby authorize any physician, hospital, clinic or insurance company or other organization, institutions or persons, that have any records or knowledge of me/the life insured or my/life insured's health, to disclose to _____ or its representatives any and all such information and expressly waive on behalf of me/the life insured or any person who has any claim or interest in any policy issued hereunder, all provisions of law forbidding any physician or surgeon from disclosing any information acquired while attending me/the life insured in a professional capacity. This authorization shall irrevocably bind my successors and assigns and remain valid, notwithstanding my/life insured's death or incapacity and a copy of this authorization shall be as effective and valid as the original.

Saya _____ No. Kad Pengenalan _____ dengan ini memberi kuasa kepada sebarang doktor, pihak hospital, klinik atau syarikat insurans atau lain-lain organisasi, institusi atau orang perseorangan yang mempunyai sebarang rekod atau pengetahuan tentang saya atau kesihatan saya, untuk mendedahkan kepada _____ atau wakilnya tentang sebarang dan keseluruhan maklumat tersebut dan secara nyata menyisihkan hak bagi pihak diri saya/hayat yang dilindungi atau sesiapa yang mempunyai sebarang tuntutan atau kepentingan dalam sebarang polisi yang dikeluarkan, ke atas semua peruntukan undang-undang yang melarang doktor atau pakar bedah daripada memberi sebarang maklumat yang diperoleh semasa merawat saya/hayat yang dilindungi ketika mereka menjalankan tugas sebagai seorang profesional. Kebenaran ini mengikat dan tidak boleh di batal oleh waris dan penerima serah hak dan akan kekal sah, tanpa mengira kematian atau ketidakupayaan saya/hayat yang dilindungi dan salinan kebenaran ini dianggap sah dan berkesan seperti dokumen asal.

We further confirm and authorize Great Eastern Life Assurance (Malaysia) Berhad as follows:-
[please tick on one (1) box only]
Dengan ini kami mengesahkan dan memberi kebenaran kepada Great Eastern Life Assurance (Malaysia) Berhad seperti berikut:-
[sila tanda pada satu (1) kotak sahaja]

☐ the bills are paid by the Employer and please reimburse eligible expenses incurred to the Employer
bil yang dibayar oleh Majikan, sila bayar balik perbelanjaan layak yang ditanggung kepada Majikan

☐ the bills are paid by the Employee and/or the Patient, and please reimburse eligible expenses incurred to the Employee
bil yang dibayar oleh Majikan dan/atau Pesakit, sila bayar balik perbelanjaan layak yang ditanggung kepada Pekerja

Signature of Employee *Tandatangan Pekerja*	Signature of Employer & Company Stamp *Tandatangan Majikan & Cop Syarikat*	Signature of Patient* *Tandatangan Pesakit**
Date: _____ *Tarikh:*	Date: _____ *Tarikh:*	Date: _____ *Tarikh:*

* The employee should sign if the patient is a dependent child
* *Pekerja dikehendaki menandatangani sekiranya pesakit adalah kanak-kanak*

MEDICAL REPORT IS NOT REQUIRED FOR TOTAL BILLS NOT EXCEEDING RM500 UNLESS SPECIALLY REQUESTED
LAPORAN PERUBATAN TIDAK DIPERLUKAN SEKIRANYA BIL TIDAK MELEBIHI RM500 KECUALI DIMINTA

HOSPITALISATION & SURGICAL CLAIM - ATTENDING PHYSICIAN'S STATEMENT
BORANG TUNTUTAN RAWATAN HOSPITAL - KENYATAAN DOKTOR YANG MERAWAT

Great Eastern
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Policy No. / *No. Polisi*	New NRIC No. / *No. KP Baru*
Policy No. / *No. Polisi*	Old NRIC/BC/Passport No. / *No. KP Lama/Sijil Kelahiran/ Paspot*
Policy No. / *No. Polisi*	Name of Patient / *Nama Pesakit*

1.	If treatment was a result from an accident, please provide details of accident. *Jika rawatan akibat kemalangan, sila kemukakan butiran berikut.* Date of Accident *Tarikh kejadian kemalangan* — Time *Masa* — AM/PM *Pagi/Petang* Nature of Accident *Jenis Kemalangan*	
2.	Hospitalisation Detail *Butiran Masuk ke Hospital* Admission No. *Nombor Pendaftaran* Date of Admission/Day Surgery *Tarikh Kemasukan Hospital/Pembedahan Harian* — Time *Masa* — AM/PM *Pagi/Petang* Date of Discharge *Tarikh Discaj* — Time *Masa* — AM/PM *Pagi/Petang*	
3.	What were the symptoms the patient complained when he/she first saw you? *Apakah simtom yang diberitahu oleh pesakit ketika pertama kali dia berjumpa dengan anda?*	
4.	**The date on which you first saw the patient for this condition.** *Sila nyatakan tarikh pertama kali anda memberi rawatan kepada pesakit bagi keadaan ini.*	**Date *Tarikh***
5.	(a) **According to the patient, how long had the patient been having these symptoms prior to the initial consultation with you?** *Berdasarkan maklumat yang diberi oleh pesakit, berapa lamakah dia telah mengalami simtom ini sebelum kali pertama menemui anda?*	
	(b) **Based on your professional opinion, how long had the patient been having these symptoms prior to the initial consultation with you?** *Pada pandangan anda, berapa lamakah dia telah mengalami simtom ini sebelum kali pertama menemui anda?*	
6.	Had the patient previously received any medical consult for the above symptom(s)? If yes, please indicate the doctor's name, address, date of consultation and provide a copy of referral letter (if any). *Pernahkah pesakit menerima perundingan perubatan untuk simtom diatas? Jika ya, sila nyatakan nama, alamat doktor tersebut, tarikh rawatan serta berikan salinan surat rujukan (jika ada).*	☐ Yes *Ya* ☐ No *Tidak* Name *Nama* Address *Alamat* Date *Tarikh*
7.	Have any investigation, test or procedure been performed? If yes, please furnish us the detail or provide a certified true copy of result. *Adakah sebarang siasatan, ujian atau prosedur dilakukan? Jika ya, sila nyatakan maklumat lanjut atau lampirkan satu salinan siasatan yang disahkan daripada dokumen asal.*	☐ Yes *Ya* ☐ No *Tidak*
8.	What was the diagnosis? *Apakah diagnosis anda?*	
9.	What is the underlying cause(s)/pathology/mechanism of injury for the above diagnosis? Please indicate the doctor's name, address and date of consultation (if any). *Apakah punca penyebab/patologi/mekanisme kecederaan bagi penyakit diatas? Sila nyatakan nama, alamat doktor tersebut dan tarikh rawatan (jika ada).*	
10.	Did you inform the patient of the diagnosis? If yes, when? *Adakah anda memberitahu pesakit tentang diagnosis tersebut? Jika ya, bila?*	☐ Yes *Ya* ☐ No *Tidak* Date *Tarikh*

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E-mail: healthcareservices@greateasternlife.com Website: www.greateasternlife.com

11.	Nature of medical treatment given/planned and/or surgery to be performed. *Apakah jenis rawatan perubatan yang diberi/dirancang dan/atau pembedahan yang akan dijalankan.*	
12.	For surgery/procedure: *Untuk pembedahan/prosedur:* (a) Indication and Nature of surgery/procedure performed *Petunjuk dan Jenis pembedahan/prosedur*	
	(b) Name of surgeon(s) *Nama pakar bedah*	
	(c) MMA OPCS code/PHFSR code *Kod MMA OPCS/Kod PHFSR*	
	(d) Date(s) of surgery/procedure performed *Tarikh pembedahan/prosedur dilakukan*	
13.	Has the patient previously been treated (outpatient) or hospitalised for this or any other disease? If yes, please furnish the details. *Pernahkah pesakit diberi rawatan secara pesakit luar atau dimasukkan ke hospital untuk rawatan penyakit ini atau penyakit-penyakit lain? Sila berikan maklumat lanjut.*	☐ Yes *Ya* ☐ No *Tidak* Date *Tarikh* Illness *Penyakit* Details of Treatment *Butir Rawatan* Hospital/Clinic *Hospital/Klinik* Address *Alamat*

14. Was the illness/condition caused directly or indirectly by the following condition. If yes, please tick.
Adakah penyakit ini secara langsung atau tidak langsung berkaitan dengan keadaan berikut. Jika ya, sila tanda.

- ☐ Pregnancy/Childbirth/Caeserean section/Miscarriage/Prenatal/Postnatal/Sterilization/Infertility.
  (If pregnancy related, gestation period _____ weeks).
  Kehamilan/Kelahiran/Kelahiran secara Pembedahan/Keguguran/Sebelum Kelahiran Anak/Selepas Kelahiran Anak/Pensterilan/Kemandulan. (Jika berkaitan dengan Kehamilan, tempoh kehamilan_____minggu).
- ☐ Drug abuse/Intoxication
  Penyalahgunaan Dadah/Kemabukan
- ☐ Nervous/Mental/Emotional/Sleeping Disorder /Alternative Therapy
  Penyakit Mental/Penyakit Gangguan Tidur/Alternatif Terapi
- ☐ Cosmetic surgery/Dental care/Refractive errors connection
  Pembedahan Kosmetik/Rawatan Pergigian/Pembetulan Penglihatan melalui Pembiasan
- ☐ AIDS/HIV/STD/VD
  AIDS/HIV/STD/VD
- ☐ Self-inflicted injuries/Suicide/Attempted Suicide
  Tindakan Melukakan Diri Sendiri/Bunuh Diri/Percubaan Bunuh Diri
- ☐ Strike/Riot/Insurrection
  Mogok/Rusuhan/Pemberontakan
- ☐ None of the above
  Semua diatas tidak berkenaan

Declaration
"I hereby certify that the information above are full, complete and true as per record from the hospital/clinic."
"Saya dengan ini mengesahkan bahawa maklumat di atas adalah lengkap dan benar mengikut rekod hospital/klinik."

_____
Signature and Stamp of Attending Physician/Surgeon
Tandatangan dan Cop Pengawai Perubatan/Pakar Bedah

Name of Physician/Surgeon _____
Nama Doktor/Pakar bedah

Qualification *Kelayakan* _____

Contact No. *No. Tel* _____

Fax No. *No. Faks* _____

Date *Tarikh* _____

Hospital/Clinic _____
Hospital/Klinik

Address *Alamat* _____

DIRECT CREDIT FACILITY FORM

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Important Notes:

1. This Direct Credit facility is only available for accounts maintained in banks participating in the Interbank GIRO payment system (IBG) in Malaysia.
2. This Direct Credit facility is not allowed for any joint bank accounts unless the Policy Owner/Payee is the primary account holder.
3. We reserve the right to release payment by cheque in the event of (a) insufficient/incorrect information having being provided in this Direct Credit Facility form, (b) payment being made to joint Payees (e.g. joint administrators or joint executors), and/or (c) failure of transfer to the beneficiary bank for any reason whatsoever.

Payee * - refers to any person/company who is the person entitled to the Policy monies, e.g. policyowner, life assured, nominee, assignee, trustee, Public Trustee/Amanah Raya, executor/executrix, administrator/administratrix, or for group employee benefit policies, employer. In relation to a Payee* who is a minor, payments shall only be made to accounts maintained by the parent or lawful guardian.

Name of Policy Owner / Payee*

NRIC No. / Company Registration No. * same as in Policy and Bank Account

Group Scheme Number * only applicable for Group Insurance

Policy No. / Certificate No. / Contract No. 1 2 3 4

Beneficiary Bank

Bank Account No.

Account Type ☐ Single Account ☐ Joint Account
(Only allowed if Policy Owner / Payee is the primary account holder)

Email Address (mandatory)

Mobile (mandatory) +

example: 012-345 6789 (Malaysia) Country Code 6 0 1 2 3 4 5 6 7 8 9

* The mobile and email address REQUIRED will be used for payment notification for the above policies/certificates/contracts.

POLICY OWNER / PAYEE AUTHORIZATION

I/We hereby:

1. Instruct the Company to pay into my / our Account all the future amount payable to me / us arising from transactions effected through the above policy (ies) until this instruction is expressly revoked in writing or replaced.
2. Confirm that I am the Account holder and have full power and authority to operate the Account / [in respect of a partnership or a body corporate], we further confirm that the person signing this form is the authorised signatory for the Account, and have full power and authority to operate the Account.
3. Confirm that the information provided by me / us in this form is true and correct and undertake to immediately inform the Company of any change in the same and will not hold the Company liable in the event that any payment transaction into my / our Account is delayed or cannot be effected due to incorrect or incomplete information being provided in this form, and/or for any other reason beyond the reasonable control of the Company.
4. Understand that the Company has the right to reject this standing instruction in the event that it is found to be payable to a third party account. I / we also understand that the Company may in its absolute discretion terminate this Direct Credit service at anytime and without assigning any reason(s) therefor.
5. Agree to immediately refund to the Company in full any monies paid into the Account which is paid in error or which I am / we are otherwise not entitled to receive.
6. Declare that in relation to payments made by the Company into the above Account, I / We :
   a. acknowledge and agree that payments made by the Company into the above-mentioned Account shall be a valid discharge of the Company's liability under the policy(ies), and that the Company shall not be liable for any damages, losses, claims, costs and/or expenses which may incur arising from such payments.
   b. agree to keep the Company indemnified of any damages, losses, claims, cost and/or expenses incurred by the Company in defending any claim arising from and/or in connection with this instruction.
7. Declare that I am not an undischarged bankrupt / [in respect of a partnership or a body corporate]. We declare that no order has been made, petition filed or resolution passed for our winding up, dissolution or liquidation or for the appointment of a liquidator, receiver, custodian or trustee for all or any part of our property or assets or for an administration order against us.
8. Agree that the personal data provided in this form may be recorded, used, disclosed, processed and stored by the Company for the purposes relating to the payment of funds in accordance with my / our instructions herein, and for the purposes of compliance with any legal or regulatory requirements.

Signature of Payee*

Name: _____

Date.: _____ (DD/MM/YY)

Signature of Witness

Name: _____

NRIC No.: _____

Contact No.: _____

Address: _____

For Office Use:

Bank Code:

Branch Code:

Reject Reason: _____

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