



**GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)
CLAIM FORM FOR GROUP HOSPITAL BENEFIT**

Untuk Kegunaan Pejabat
Previous Claims
No : RM :
Admitted/Ex-Gra
RM :

Hospital Benefit would not be paid if :-

- (a) It is a pre-existing illness or accident which happened before the first premium payment or while the policy lapsed.
- (b) In the first 6 weeks after the policy is reinstated, unless the injury was due to accident.

Name of Union : _____ Scheme No : _____

SECTION 1 TO 5 SHOULD BE FILLED UP BY CLAIMANT

SECTION 1 : PLEASE TICK () EITHER BOX [A] OR [B]

- [A] I am claiming for only Daily Cash Benefit (per night stay)
- [B] I am claiming for both Daily Cash Benefit (per night stay) and Medical Reimbursement of my bill

SECTION 2 : PATIENT'S DETAILS

Name of Patient : _____ Member Spouse
 Date of Birth : _____ Sex : Male Female
 Identity Card No. (Old) : _____ Identity Card No. (New) : _____
 Occupation : _____ Certificate No. : _____
 Address : _____
 Monthly Premium : RM _____ Hospital Benefit Per Night : RM _____

SECTION 3 :

Nature of Injury or Illness : Accident Sickness Pregnancy
ACCIDENT
 Date : _____ Time : _____ Place : _____
 Were you at work at the time of the accident? YES NO
 How did the accident occur? _____
SICKNESS
 Date of first occurrence : _____ Have you been treated for this condition before? YES NO
 If YES please complete (i), (ii), (iii) and (iv) :
 (i) Date and duration of first treatment : _____
 (ii) Date and duration of other treatment (if any) : _____
 (iii) Name of physician : _____ (iv) Clinic/Hospital : _____

SECTION 4 : PRESENT CLAIM FOR THE HOSPITALISATION

Name of Hospital : _____
 Date Admitted : _____ Date of Discharged : _____

SECTION 5 : MEDICAL INFORMATION AUTHORISATION AND DECLARATION

I hereby authorize any hospital of physician who has attended me to release all information concerning this claim as requested by Great Eastern Life Assurance (Malaysia) Berhad. A photocopy of this authorization shall be as valid as the original. I declare that the above particulars and answers are full, complete and true and that I have not withheld any relevant information.

Date Signature of Patient

SECTION 6 : DECLARATION (BY UNION OFFICER)

I hereby confirm the above statements are full, complete and true to the best of my knowledge.

Date Designation Signature

NOTES : Documents needed :-

- 1) Claims up to RM1,000/= (a) Original Medical Bill (b) Discharge Note (c) Medical Certificate (MC)
- 2) Claims above RM1,000/= (a) Original Medical Bill (b) Discharge Note (c) Medical Certificate (MC) (d) Medical Report

Please return completed form to : **KPPK Semenanjung Malaysia, 13B Jalan Murai Dua, Kompleks Batu , Off Jalan Ipoh, 55100 Kuala Lumpur Tel : 03-62535725 or Tony Ng & Associates, 39 (1st Floor) Lebuhs Bishop, 10200 Penang Tel : 04-2628998**