(applicable for policy below 5 years)

4

DEATH CLAIM
DOCTOR'S STATEMENT

Policy No.	New NRIC No.
Policy No.	Old NRIC/Birth Certificate/ Passport No.
Policy No.	Name of Deceased
Policy No.	

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 for Death benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any fee incurred in completing this form, it will be borne by claimant)

SECTION I: DECEASED'S MEDICAL RECORD

1. Date of Death — ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

2. Height / Weight — ________ (cm) ________ (kg)

3. Are you the Deceased's regular / family doctor? If "YES", since what date?
   ☐ Yes ☐ No
   ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

4. Has the Deceased 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 of Clinic / Hospital and Address

5. Did you attend to the Deceased's last illness? — ☐ Yes ☐ No
   If "YES",
   (i) What were the symptoms presented? — (i) ________
   (ii) Date of symptoms started — (ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
   (iii) What was the diagnosis? — (iii) ________

6. Was the Deceased hospitalised? — ☐ Yes ☐ No
   If "YES", please state the:
   (i) Name of hospital admitted — (i) ________
   (ii) Date of First admission — (ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
   Date of Last admission — ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
   (iii) Name(s) of attending doctor(s) — (iii) ________

7. Was other doctor referring the Deceased to you? — ☐ Yes ☐ No
   If "YES", please state the name(s) and address(es) of the attending doctor(s) ________

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8. (i) Please state the disease(s) or condition(s) DIRECTLY leading to death with approximate interval between onset and death.

Cause of Death	Approximate Interval between onset and death			
	Years	Months	Days	Hours

(ii) Name of doctor(s) and hospital(s) that made the diagnosis.

(iii) Was the Deceased / family been informed of the diagnosis?

☐ Yes ☐ No ☐ Information unavailable

9. What is the underlying cause of the illness as per diagnosis above?

10. (a) Was there any predisposing cause(s) of the Deceased's death in relation to his/her habits (use of alcohol, narcotics, etc), family history, occupation?

☐ Yes ☐ No

If "YES", please provide details:

(b) Was there any predisposing cause(s) of the Deceased's death in relation to his/her previous illness?

☐ Yes ☐ No

If "YES", please provide details:

11. Any other information that you feel may be relevant?

SECTION II: This section is applicable to ACCIDENTAL DEATH only

Please attach certified true copies of ALL the relevant laboratory evidences / tests available

☐ Post-mortem or Autopsy report ☐ Alcohol / drug test report

1. Date and Time of Accident ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) ☐☐ - ☐☐ (am/pm)

2. Nature of Accident (please tick only one)

☐ Road Traffic Accident ☐ Fall from Height / Building
☐ Drowning ☐ Industrial / Accident at Work
☐ Fire ☐ Air / Rail / Ship Disaster
☐ Explosion ☐ Sports Related
☐ Other: Please describe:

3. Please describe how the accident happen.

4. Was the Deceased suspected to be under the influence of any alcohol or drugs?

☐ Yes ☐ No

If "YES", was there any sample of urine or blood sent for further test?

☐ Yes ☐ No

5. In your opinion / investigation, do you think that death was resulted from the accident?

☐ Yes ☐ No

If "NO", what do you think was the cause of death? Please elaborate in detail.

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, do hereby declare that I have answered the above questions are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name:

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

LETTER OF AUTHORISATION/CONSENT - To Obtain Further Information for Death

SURAT PEMBERIKUASA/KEBENARAN - Untuk Mendapatkan Maklumat Lanjut untuk Kematian

Policy No. *No. Polisi*		New NRIC No. *No. KP Baru*	- -
Policy No. *No. Polisi*		Old NRIC/Birth Certificate/ Passport No. *No. KP Lama/Sijil Kelahiran/Paspot*	
Policy No. *No. Polisi*			
Policy No. *No. Polisi*		Name of Deceased *Nama Si Mati*	

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, insurance company or other organization, institution or individual concerned ("the Information Provider(s),") that may have any records or knowledge of the employment, financial, health or medical history of ______________________ ("the Assured") and to provide such information to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)("the Company) or its authorised agents and/or employees.

I expressly waive on behalf of myself and/or as a next-of-kin of the Assured and for his/her estate all provision of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on the Assured in a professional and/or client capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorisation/consent is irrevocable and a copy of it will have the same effect and validity as the original.

Saya dengan ini memberi kuasa dan mengizinkan mana-mana pegawai perubatan, doktor, pakar bedah, klinik, hospital, pusat perubatan, syarikat insurans atau organisasi, institut atau orang perorangan ("Pemberi Maklumat") yang mungkin mempunyai apa-apa rekod atau mengetahui tentang pekerjaan, kewangan, kesihatan atau sejarah perubatan ______________________ ("Pemegang Polisi") untuk memberi maklumat kepada Great Eastern Life Assurance (Malaysia) Berhad ('Syarikat") atau mana-mana ejen/kakitangannya yang diberi kuasa.

Saya juga tidak ragu-ragu untuk mengetepikan bagi pihak saya dan/atau sebagai waris terdekat Pemegang Polisi dan untuk harta pusakanya segala peruntukan undang-undang atau etika profesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai Pemegang Polisi dalam bidang kuasa sebagai profesional dan/atau pelanggan dan saya juga memberi pelepasan kepada Pemberi Maklumat dan ejen/kakitangannya daripada apa-apa liabiliti kerana memberi maklumat tersebut kepada syarikat.

Surat pemberikuasa/kebenaran ini adalah muktamad dan salinannya juga memberi hak dan pengesahan yang sama dengan yang asal.

Signature of Claimant
Tandatangan Penuntut

Name: ______________________
Nama
NRIC No.: ______________________
No. KP
Relationship with the Deceased: ______________________
Hubungan dengan Si Mati
Address: ______________________
Alamat ______________________
Date: ______________________
Tarikh

CLM-AUTHO-V02-022014

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

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DIRECT CREDIT FACILITY FORM

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 3
2 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:

CSD-FDCFF-V02-062016 (ENG)

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 8198
Website: greateasternlife.com Email: wecare-my@greateasternlife.com

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