(7)

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

Great Eastern
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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

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 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 dan 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

TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT

Great Eastern
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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 conditlon, 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) _____

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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)			

DIRECT CREDIT FACILITY FORM

Great Eastern
A member of the OCBC Group

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) + *Country Code* 6 0 1 2 3 4 5 6 7 8 9

example: 012-345 6789 (Malaysia)

** 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)
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