

FOREIGN MAID CLAIM FORM

Please submit the duly completed Claim Form with the documents required to expedite claim processing.
 The furnishing and/ or acceptance of this form shall not be regarded as a waiver by the Company of its rights and the Company makes no admission of liability on the part of the Company.

GENERAL INFORMATION	
Policy number	Claim number
Name of Policyholder	
NRIC Number	Mobile number
Correspondence Address	
Email Address	
Name of Insured Person	
Passport Number	

ACCIDENT RELATED
1. Date of Accident
2. Time of Accident
3. Place of Accident
4. Please describe in details on how did the accident occur.
5. Please states in detail the injuries that the Insured Person sustained.

ILLNESS RELATED								
1. Nature of illness/ symptoms								
2. Date of admission								
3. How long had the Insured Person been having the symptoms prior to this admission?								
4. What was the diagnosis ?								
5. Please provide details of doctor(s) who first attended to you after the accident and state when he attended to you.								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%; padding: 2px;">Date of visit</th> <th style="width: 30%; padding: 2px;">Name of doctor</th> <th style="width: 45%; padding: 2px;">Name of hospital/ clinic & address</th> <th style="width: 10%; padding: 2px;">Contacts No.</th> </tr> </thead> <tbody> <tr> <td style="height: 30px;"></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Date of visit	Name of doctor	Name of hospital/ clinic & address	Contacts No.				
Date of visit	Name of doctor	Name of hospital/ clinic & address	Contacts No.					
6. Please furnish name, address & contact number of the Insured Person's usual attending doctor other than above.								
7. Have you made any claim with regards to this loss with other insurer/ party/ SOCSO. If yes, please give details.								

DOCUMENT CHECKLIST

- Medical report
- Copy of medical certificate(s)
- Original medical receipt(s) and bill(s)
- Copy of police report (if involved motor vehicle accident or criminal incident)
- Copy of Passport & working permit

For Fatal Accident - in addition to above :

- Copy of death certificate
- Copy of detailed post-mortem report or detailed medical report (if post-mortem report is not available)
- Original repatriation receipt

* **Note :** Further documents may be requested where necessary.

DATA PROTECTION NOTICE

By submitting this form, you are providing personal information to the Company. The Company will be processing your personal information provided in this form and/ or further information and data that may be required by the Company either from you or from any third parties. Your personal information may be used, recorded, stored, disclosed or otherwise processed by or on behalf of the Company (and its successors in title) for the purpose of (i) processing your claim or investigation or analysis of such claim; and (ii) ascertaining your claims history in order to improve claims processing and prevent fraudulent claims. By submitting this form, you consent and authorize the Company to obtain and verify any information about you from you or from any third parties which the Company may require in connection with your claim. Such consent and authorization herein shall extend to any information obtained from any of the insurance policy(ies) presently provided to you, any new application to the Company for insurance, such historical financial or credit records, data or information whether or not provided personally. The information that you have provided to the Company is necessary. If you do not provide the Company with such information, the Company may not be able to respond to your claim. The Company may disclose and/ or provide your personal information to the Company's Authorised Representative or any other third party, necessary for the processing of your claim. You may access certain personal information held by the Company based on the applicable data protection laws of Malaysia. You may access your personal information during office hours by calling Customer Service Care at 1300- 1300 88. If you have any inquiry or complaint (such as limiting the processing of certain information), you may contact our Customer Service Care at 1300- 1300 88, or write to the Company. The Company may charge a reasonable fee for access. If you can show that the personal information held by the Company is not accurate, complete and up to date, the Company will take reasonable steps to ensure it is accurate, complete and up to date upon receiving your verification/ feedback. For more information on how the Company deals with your personal information please log on to www.greateasterngeneral.com and read the Company's Client Charter and Privacy Policy or contact the Company's Authorised Representative for a copy.

DECLARATION

I, the Insured Person/ Claimant, 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 Insured Person's right to be compensated shall be absolutely forfeited. I, the Insured Person/ Claimant, hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organisation, institutions or persons that may have any records or knowledge of my/ the Insured Person's health or medical history ("Information Provider"), to provide such information to Overseas Assurance Corporation (Malaysia) Berhad (102249-P) ("the Company") and its authorised service provider and/ or its employees in order to process my insurance claim. I, the Insured Person/ 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. A copy of this form shall be effective and valid as the original.

Signature of Policyholder

(Please affix company rubber stamp, where applicable)

Name :

NRIC No. :

Date :

Signature of Insured Person/ Claimant

Name :

NRIC No. :

Date :

Signature of Witness

Name :

NRIC No. :

Date :