Great Eastern General Insurance (Malaysia) Berhad (102249-P)
(Formerly known as Overseas Assurance Corporation (Malaysia) Berhad)
Level 18, Menara Great Eastern, 303, Jalan Ampang, 50450 Kuala Lumpur
General Line: +603 4259 8888 Fax: +603 4813 0055
Customer Service Careline: 1300-1300 88
Website: www.greateasterngeneral.com

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MEDICAL CLAIM FORM

Policy No.:

Please submit the duly completed Hospitalisation, Surgical & Other 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.

☐ Admission / Day Surgery / Day Care Procedure	☐ Critical Illness Claim / Dread Disease Claim
☐ Pre / Post Hospitalisation	☐ Death Claim
☐ Outpatient Cancer / Kidney Dialysis / Pysiotheraphy Treatment	☐ Emergency Sickness / Accidental Outpatient Treatment
☐ Hospital Cash Allowance Claim	☐ Others

DETAILS OF PERSON SUBMITTING CLAIM

1. Name:	
2. Email Address:	3. Contact No:

DETAILS OF POLICYHOLDER / EMPLOYER (GROUP POLICY)

1. Policyholder's / Employer's Name:	
2. Company Registration / NRIC No:	
3. Current Correspondence Address:	
4. Contact No:	5. Email Address:

DETAILS OF INSURED PERSON / EMPLOYEE (GROUP POLICY)

1. Name of Insured Person / Employee:	2. Gender: Male / Female
3. NRIC / Passport No:	4. Occupation:
5. Contact No:	6. Email Address:
7. Correspondence Address:	

DETAILS OF PATIENT (IF OTHER THAN EMPLOYEE)

1. Name of Patient:	
2. NRIC / Passport No:	3. Relationship to Employee:

HOSPITALISATION DUE TO ACCIDENT

1. Date:	2. Time:	3. Place:
4. How did the accident occur:		5. Please state the nature and extent of injury:

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HOSPITALISATION DUE TO ILLNESSES / DISEASES	
1. Nature of Illness / Symptoms:	
2. Date symptoms first appeared:	3. Date of First Consultation:
4. Date of Admission (if any):	5. Date of Discharge (if any):

DETAILS OF DOCTORS WHO TREATED YOU FOR THIS ILLNESS / INJURY / CONDITION			
Date of Consultation	Name of Doctor	Name & Phone No. of Clinic / Hospital	Referred by Doctor / Clinic(if any)

DETAILS OF REGULAR ATTENDING DOCTOR
1. Name of Treating Doctor:
2. Name of Clinic / Hospital:
3. Contact No:

OVERSEAS TREATMENT
1. Name of Hospital:
2. Purpose of the Overseas Trip:
3. Intended Duration of Overseas Trip:

OTHER INFORMATION
1. Give details of other health / medical insurance cover (if any):
2. Policy / Membership No:

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DOCUMENT CHECKLIST

- ☐ Fully completed Claim Form
- ☐ Medical Report fully completed by the attending physician
- ☐ Original Itemised Breakdown of Medical Bills
- ☐ Original Payment Receipts
- ☐ Copy of Investigation Reports (i.e. blood test / imaging report / HPE / etc)
- ☐ Copy of Identity Card
- ☐ Copy of Passport/ Student Permit (For Group Student Policy)

LIST OF ORIGINAL RECEIPT(S) SUBMITTED (INCLUDING DEPOSIT / REFUND / FINAL RECEIPTS)

Receipt Date	Receipt No.	Receipt Amount	Receipt Date	Receipt No.	Receipt Amount

Total Amount Incurred: _____

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.

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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 Persons'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

(For Group Policyholder, please also affix the Group Policyholder's Company rubber stamp)

Name :

NRIC No. :

Date :

_____

Signature of Insured Person / Patient

Name :

NRIC No. :

Date :

_____

Signature of Witness

Name :

NRIC No. :

Date :