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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WORKMEN COMPENSATION 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	
Company Registration Number	Contact number
Correspondence Address	
Trade/ Business	Email Address
Name of Insured Person	
Nationality	NRIC/ Passport No.
Marital Status	

DETAILS OF ACCIDENT		
1. Date of Accident	2. Place of Accident	
3. Did the accident happen during the course of employment?	☐ Yes, time : _____	☐ No
4. Please describe in details on how did the accident occur.		
5. Please state in detail the injuries the Insured Person sustained.		
6. Please provide details of doctor(s) who first attended to you after the accident and state when he attended to you.		

Date of visit	Name of doctor	Name of hospital/ clinic & address	Contacts No.

7. State occupation on which Insured Person is employed.
8. On what date did the Insured Person actually cease work ?
9. What date did the Policyholder receive notice of the accident and from whom?
10. Was anyone superintending the work the Insured Person was engaged upon? If so, please state name.
11. What was the general nature of the contract or work going on?
12. Is the Policyholder satisfied that the Insured person has met with a genuine accident of employment?
13. Is the Insured Person in the Policyholder's direct employment? If not, please give name and address of contractor.
14. Was the Insured Person under the influence of alcohol or drugs at the time of accident? If Yes, please give full details.

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15. Was the Insured Person guilty of any misconduct or disobedience to order or rules? If so, please give full details.

16. State the names of persons who witnessed the accident.

a)

b)

17. Have you made any claim with regards of this accident with other insurer/ party/ SOCSO. If yes, please give details.

DOCUMENT CHECKLIST

- ☐ Medical report
- ☐ Original medical receipt(s) and bill(s)
- ☐ Copy of medical certificate(s)
- ☐ Copy of police report (if involved motor vehicle accident or criminal incident)
- ☐ Copy of employment letter & 3 months salary slips prior to the loss
- ☐ Copy of Passport & working permit
- ☐ Copy of valid driving licence at the time of accident (if involved motor vehicle accident & driving)

For Fatal Accident - in addition to above :

- ☐ Copy of death certificate
- ☐ Copy of detailed post-mortem report

*** 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.

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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
(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 :