



GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)  
**CLAIM FORM FOR GROUP HOSPITAL BENEFIT (Scheme No. GS2072/ GS2415)**

Name Of Union: \_\_\_\_\_ Scheme No: \_\_\_\_\_

**SECTION 1 TO 5 SHOULD BE FILLED UP BY CLAIMANT**

**SECTION 1: PLEASE TICK (  ) EITHER BOX [ A ] OR [ B ]**

**SECTION 2: PATIENT' S DETAILS**

Name of Patient: \_\_\_\_\_ Member \_\_\_\_\_ Spouse \_\_\_\_\_  
Children \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Identity Card No. (Old): \_\_\_\_\_ Identity Card No. (New): \_\_\_\_\_  
Occupation: \_\_\_\_\_ Certificate No. : \_\_\_\_\_  
Address: \_\_\_\_\_ Tel. No. : \_\_\_\_\_

Monthly Premium: RM \_\_\_\_\_

Hospital Benefit Per Night: RM \_\_\_\_\_

**SECTION 3:**

Nature of Injury or Illness: \_\_\_\_\_ Accident \_\_\_\_\_ Sickness \_\_\_\_\_ Pregnancy \_\_\_\_\_

***ACCIDENT***

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Place: \_\_\_\_\_  
Were you at work at the time of the accident? YES \_\_\_\_\_ NO \_\_\_\_\_  
How did the accident occur? \_\_\_\_\_

***SICKNESS***

Date of first occurrence: \_\_\_\_\_  
Have you been treated for this condition before? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES please complete (i), (ii), (iii) and (iv):

(i) Date and duration of first treatment :

(ii) Date and duration of other treatment (if any) :

(iii) Name of physician :

(iv) Clinic/Hospital :

**SECTION 4: PRESENT CLAIM FOR THE HOSPITALISATION**

Name of Hospital:

Date Admitted:

Date of Discharged:

**SECTION 5: MEDICAL INFORMATION AUTHORISATION AND DECLARATION**

I hereby authorize any hospital of physician who has attended me to release all information concerning this claim as requested by Great Eastern Life Assurance (Malaysia) Berhad. A photocopy of this authorization shall be as valid as the original. I declare that the above particulars and answers are full, complete and true and that I have not withheld any relevant information.

Date

Signature of Patient

**SECTION 6: DECLARATION (BY UNION OFFICER)**

I hereby confirm the above statements are full, complete and true to the best of my knowledge.

Date

Designation

Signature

**If the Hospital Benefit Claim is for Spouse or Children, kindly indicate the Member' s**

**Name: .....**

**NOTES: Documents needed:-**

- 1) Claims up to RM1,000/=
  - (a) Original Medical Bill (b) Discharge Note (c) Medical Certificate (MC)
- 2) Claims above RM1,000/=
  - (a) Original Medical Bill (b) Discharge Note (c) Medical Certificate (MC) (d) Medical Report

Please return completed form to:

**1. KPPK SEMENANJUNG MALAYSIA**  
**Jalan Murai Dua, Kompleks Batu,**  
**Off Jalan Ipoh, 55100 Kuala Lumpur**  
**Tel: 03-62535725 (attn: Pn Nagamani)**

**OR**

**2. Tony Ng & Associates**  
**39 Lebuh Bishop,**  
**10200 Penang**  
**Tel:04-2628998 (attn: Mr Chan)**