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)**