CUEPACS TAKAFUL LIVING CARE

RL MAJUSINAR PLUS SDN BHD (1265909-V)

Pejabat:
Bangunan PSM, Level 3, No. 17B, Jalan Bangsar, 59200 Kuala Lumpur.
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KEPADA

TUAN/PUAN,

TUNTUTAN HILANG UPAYA KEKAL & SEPARA KEKAL
SKIM INSURANS BERKELOMPOK CUEPACS – GPT 20/21

Dimaklumkan bahawa untuk tuntutan hilang upaya kekal & separa kekal, pihak kami memerlukan dokumen berikut untuk proses selanjutnya :-

1. Borang Tuntutan Takaful - Borang Tuntutan TPD/PPD (Borang GETB)
2. Borang Tuntutan Takaful - Penyataan Doktor TPD/PPD (Borang GETB)
3. Borang Tuntutan Takaful - Surat Pemberikuasa/Kebenaran (Borang GETB)
4. Salinan Kad Pengenalan/ Sijil Kelahiran yang diakui sah(Pencadang,Orang yang dilindungi & Orang yang menuntut)
5. Bukti Documen bagi hubungan keluarga antara Pencadang , Orang yang Dilindungi dan Orang yang menuntut (ch: Sijil Kelahiran/Sijil Perkhawinan
6. Salinan Laporan Polis yang diakui sah (untuk Kemalangan sahaja)
7. Laporan Perubatan Tambahan (jika ada)
8. Salinan Laporan dan Surat dari Lembaga Perubatan yang diakui sah (SOCSO)
9. Salinan Surat Pemberhentian kerja dari majikan yang diakui sah (jika ada)
10. Salinan semua Laporan Makmal dan Penyiasatan yang diakui sah (jika ada)

**** PERHATIAN: SEMUA DOKUMEN HENDAKLAH DIAKUI SAH DARIPADA DOKTOR @ KETUA UNION**

****PERMOHONAN HENDAKLAH DIPOSKAN MENGIKUT ALAMAT KAMI DI BANGSAR DAN PERMOHONAN INI TIDAK BOLEH DIFAKSKAN KEPADA KAMI.**

****PIHAK GETB AKAN MEMINTA DOKUMENTASI TAMBAHAN SEKIRANYA MEMERLUKAN MAKLUMAT LAIN**

SEKIAN, TERIMA KASIH.

TOTAL AND PERMANENT DISABILITY BENEFITS CLAIM FORM - CLAIMANT'S STATEMENT

BORANG TUNTUTAN FAEDAH HILANG UPAYA TOTAL & KEKAL - KENYATAAN PENUNTUT

Certificate No. *No. Sijil*

Certificate No. *No. Sijil*

Certificate No. *No. Sijil*

Certificate No. *No. Sijil*

New NRIC No. *No. KP Baru*

Old NRIC/Birth Certificate/ Passport No. *No. KP Lama/Sijil Kelahiran/No. Pasport*

Name of Person Covered *Nama Orang yang Dilindungi*

Handphone No. *No. Telefon Bimbit*

A. PERSON COVERED'S PARTICULARS *BUTIR-BUTIR ORANG YANG DILINDUNGI*

1. Current correspondence address *Alamat surat-menyurat terkini*

2. Occupation and exact duties *Pekerjaan dan kerja sebenar*

3. a) Employer's/Business Name *Nama majikan/syarikat*
   b) Company Registration No. *No. Pendaftaran Syarikat*

4. Employer's/Business's full address *Alamat lengkap majikan/syarikat*

5. Employer's / Business' Telephone No. *No. Telefon Majikan / Syarikat*

6. Does person covered have any certificate with other takaful operators / insurers?
   Adakah orang yang dilindungi mempunyai sijil dengan pengendali takaful / syarikat insurans yang lain?
   If "Yes", please provide the details.
   Jika "Ya", sila nyatakan butir-butir tersebut.

1. _____
2. _____
3a) _____
3b) _____
4. _____
Postcode *Poskod:* _____
5. _____
6. ☐ Yes *Ya* ☐ No *Tidak*

Certificate / Polisi No. *No. Sijil / Polisi*	Takaful Operator / Company *Pengendali Takaful / Syarikat*

B. PAYMENT MODE *CARA PEMBAYARAN*

How do you wish to receive your claims payment? *Bagaimana anda ingin menerima pembayaran wang tuntutan anda?*

☐ Direct Credit (please attach Direct Credit Form for Claims). *Kredit Langsung (sila sertakan Borang Kredit Langsung bagi Tuntutan)*

☐ Mail to current correspondence address. *Mel ke alamat surat-menyurat terkini*

☐ Through authorised personnel to collect cheque (please attach Letter of Authorisation). *Melalui nama yang diberi kuasa untuk mengutip cek bagi pihak (sila sertakan Surat Kebenaran)*

☐ To be collected by claimant at Great Eastern Takaful's Office at _____
Dituntuti oleh penuntut di Pejabat Great Eastern Takaful

* Standing Instruction from Group Master Certificate Owner applies for Group certificate(s).
** Arahan Tetap daripada Pemilik Sijil Berkelompok akan dikenakan untuk sijil Berkelompok.*

C. RECORD OF MEDICAL CONSULTATIONS *REKOD RAWATAN PERUBATAN*

(1) Give below the details of all doctors or specialists who have been consulted in connection with your disability:-
Berikan butir-butir doktor atau pakar yang merawat anda untuk hilang upaya di bawah:-

Name *Nama*	Address *Alamat*	Consultation Date *Tarikh Rawatan*

(2) If you were admitted to a hospital or similar institution, please supply the following details:
Jika anda dimasukkan ke hospital atau lain-lain institusi, berikan butir-butir berikut:

Name of hospital or institution *Nama hospital atau institusi*	Date of Admission *Tarikh Masuk*	Date of Discharge *Tarikh Keluar*	Diagnosis *Diagnosis*

(3) Please provide the name and address of your regular doctor/clinic if different from above (1) or (2) :-
Sila berikan nama dan alamat pegawai perubatan/klinik yang anda biasa berjumpa, jika lain daripada (1) atau (2) yang di atas :-

_____
_____
_____

CLM-TPDCF-V05-032016-TAKAFUL

D. GENERAL *UMUM*

1. What is the highest level of education do you have?
   Tahap pendidikan tertinggi yang diperolehi?
   1. ☐ Primary *Sekolah rendah* ☐ Degree *Ijazah*
      ☐ Secondary *Sekolah menengah* ☐ Post Graduate *Lepasan Ijazah*
      ☐ Diploma *Diploma* ☐ Others *Lain-lain* _____
2. Are you currently confined to
   Adakah anda kini terlantar di
   2. ☐ Bed *Katil* ☐ House *Rumah* ☐ Hospital *Hospital*
3. When were you last able to work?
   Tarikh terakhir anda boleh bekerja?
   3. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
4. State the date when you are expected to resume your work and daily activities.
   Nyatakan tarikh anda dijangka kembali bekerja dan menjalankan aktiviti harian anda.
   4. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
5. If your service is terminated, please confirm the effective date.
   Jika perkhidmatan anda ditamatkan, sila nyatakan tarikh berkuatkuasa.
   5. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*

E. PARTICULARS OF OCCUPATION *BUTIR-BUTIR PEKERJAAN*

Please list the jobs held in the past 3 years. *Senaraikan pekerjaan anda untuk tempoh 3 tahun yang lepas.*

Dates (From - To) *Tarikh (Dari - Hingga)*	Job Title *Nama Jawatan*	Employer's Address *Alamat Majikan*	Exact Duties of Work *Jenis Kerja Sebenar*	Average Monthly Income (RM) *Pendapatan Purata Bulanan (RM)*

F. PARTICULARS OF LATEST EMPLOYMENT *BUTIR-BUTIR PEKERJAAN TERKINI (SILA NYATAKAN DENGAN LANJUT)*

WORK AREA *SKOP PEKERJAAN*

1. What kind of environment do you work in?
   Persekitaran tempat kerja anda?
   1. ☐ Office *Pejabat* ☐ Factory *Kilang* ☐ Others *Lain-lain* _____
2. Are you in management or supervisory capacity?
   Adakah anda menjalankan tugas-tugas pengurusan atau penyeliaan?
   2. ☐ Yes *Ya* ☐ No *Tidak*
3. Do you operate any machinery or special equipments?
   Adakah anda mengendalikan mesin atau alat-alat khas yang lain?
   3. ☐ Yes *Ya* ☐ No *Tidak*

JOB SKILLS *KEMAHIRAN PEKERJAAN*

4. What is the qualification needed for the job?
   Kelulusan yang diperlukan dalam pekerjaan anda?
   4. _____
5. Any special skills required?
   Adakah kemahiran khas diperlukan?
   5. _____
6. What level of practical experience is required?
   Apakah tahap pengalaman praktikal yang diperlukan?
   6. _____

G. TRAVEL & BUSINESS HOURS *PERJALANAN KE TEMPAT KERJA DAN WAKTU BEKERJA*

1. What is your normal working hours and days?
   Apakah waktu dan hari bekerja yang biasa?
   1. _____
2. Are you required to work on shift, Sunday or on-call?
   Adakah anda diperlukan bekerja syif, pada hari Ahad atau bila dipanggil?
   2. _____
3. How do you go to work?
   Bagaimanakah anda pergi ke tempat kerja?
   3. _____
4. What is the distance of travel to go to your normal place of work?
   Jarak perjalanan ke tempat kerja anda?
   4. _____
5. Does your work require you to: *Adakah pekerjaan anda memerlukan anda untuk:*
   - ☐ Driving a car *Memandu kereta*
   - ☐ Driving other vehicles *Memandu kenderaan lain*
   - ☐ Climbing ladders or heights *Memanjat tangga atau tempat tinggi*
   - ☐ Travelling away from your normal place of work *Keluar dari tempat kerja yang biasa*
   - ☐ Other physical exertions. Please specify. *Lain-lain penggunaan tenaga fizikal. Sila nyatakan.*
   - ☐ Carrying heavy loads *Membawa barangan berat*
   - ☐ Lifting heavy loads *Mengangkat barangan berat*
   - ☐ Crawling or kneeling *Merangkak atau melutut*

_____

H. TO BE COMPLETED BY A SELF-EMPLOYED PERSON ONLY
UNTUK DIISI OLEH ORANG YANG BEKERJA SENDIRI SAHAJA

1. Please name your business/Company *Berikan nama perniagaan/Syarikat anda*	1. _____
2. What is the nature of your business? *Jenis perniagaan anda?*	2. _____
3. Are there any other proprietors or directors of the business? How many? *Adakah terdapat pemilik atau pengarah yang lain di dalam perniagaan ini? Berapa orang?*	3. _____
4. Please provide your business registration number and your Company registration number, if incorporated. *Sila berikan no. pendaftaran perniagaan atau Syarikat, jika didaftarkan.*	4. _____

I. TO BE COMPLETED IF DISABILITY CAUSED BY AN ACCIDENT
UNTUK DIISIKAN JIKA HILANG UPAYA DISEBABKAN OLEH KEMALANGAN

1. When did the accident happen? *Bila kemalangan berikut berlaku?*	1. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)* _____ a.m. / p.m. *pagi / petang*
2. Where did the accident happen? *Di mana kemalangan tersebut berlaku?*	2. _____
3. Describe in detail how the accident happened. *Nyatakan secara terperinci bagaimana kemalangan berlaku*	3. _____
4. Describe the extent of the injuries sustained in the accident. *Nyatakan tahap kecederaan yang dialami akibat kemalangan.*	4. _____

J. TO BE COMPLETED IF DISABILITY CAUSED BY AN ILLNESS
UNTUK DIISIKAN JIKA HILANG UPAYA DISEBABKAN OLEH PENYAKIT

1. Please fully describe the condition or the symptoms. *Nyatakan dengan terperinci keadaan atau tanda-tanda penyakit anda.*	1. _____
2. When did the symptoms/condition first appear? *Bilakah tanda-tanda/keadaan itu mula-mula timbul?*	2. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
3. When did you first consult doctor for the symptoms? *Bilakah anda berjumpa doktor buat pertama kali mengenai tanda-tanda penyakit anda?*	3. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
4. What is the exact diagnosis? *Apakah keputusan diagnosis?*	4. _____
5. When was the diagnosis first made known to you? *Bilakah anda diberitahu megenai diagnosis anda?*	5. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) *(hh/bb/tttt)*
6. Provide the name and address of the doctor who had made the diagnosis? *Berikan nama dan alamat doktor yang telah membuat diagnosis tersebut?*	6. _____
7. What tests or investigations were done to confirm the diagnosis? *Apakah ujian atau penyiasatan yang telah dibuat untuk mengesahkan diagnosis itu?*	7. _____
8. What are the treatments you undergoing currently? *Apakah rawatan yang diterima sekarang?*	8. _____

9. Were you suffering from any other illness or related conditions prior to the onset of the disability? Please state the illness or condition and the details of treatment (by whom, address and when).
Adakah anda menghidap apa-apa penyakit lain atau keadaan yang berkaitan sebelum hilang upaya bermula? Sila nyatakan penyakit atau keadaan dan butir-butir rawatan (oleh siapa, alamat dan bila).

_____

_____

Confirmation On GST Registration, Declaration & Authorisation By The Certificate Owner / Person Covered / Claimant
Pengesahan Pendaftaran Cukai Barang dan Perkhidmatan ("CBP"), Pengisytiharan & Kebenaran Oleh Pemilik Sijil / Orang Yang Dilindungi / Pihak yang Menuntut

☐ Please tick if Certificate Owner is GST registered (leave blank if not GST registered)
Sila tandakan jika Pemilik Sijil telah mendaftar CBP (kosongkan jika tidak mendaftar CBP)

GST No. : _____
No. CBP

I, the Person Covered / Certificate Owner / Claimant understand and agree that, GREAT EASTERN TAKAFUL BERHAD (916257-H) ("GETB") shall rely on my confirmation in respect of the Certificate Owner GST registration provided above for GST tax credit purposes. I further agree, that in the event any action, claim or proceeding is taken against GETB and / or any fine, charge, penalty or any other GST liability is imposed on GETB as a result of relying on my incorrect confirmation on the Certificate Owner GST registration, I undertake to hold GETB harmless and keep GETB indemnified to the fullest extent permitted by law.

I 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/Person Covered's right to be compensated shall be absolutely forfeited. I, the Person Covered / Certificate Owner / Claimant hereby authorize and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company, takaful operator or other organization, institutions or persons that may have any records or knowledge of my / Person Covered's health or medical history ("Information Provider"), to provide such information to GETB and its authorized service provider and/or its employees in order to process my Takaful claim. I, the Person Covered / Certificate Owner / Claimant, expressly waive on behalf of myself or any other person who shall have any claim or interest in any certificate 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.

I, the Person Covered / Certificate Owner / Claimant, hereby authorize and give my consent, to the deduction of monies due to GETB from the claim proceeds payable pursuant to any certificate hereunder, including but not limited to any contribution due, advance benefit paid, erroneous and / or payment made in excess of any claim amount. This authorisation shall irrevocably bind my successors and assignees and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be effective and valid as the original.

Saya, Orang yang Dilindungi / Pemilik Sijil / Pihak yang Menuntut, memahami dan bersetuju bahawa GREAT EASTERN TAKAFUL BERHAD (916257-H) ("GETB") akan bergantung terhadap pengesahan daripada saya berhubung dengan pendaftaran CBP Pemilik Sijil seperti dinyatakan di atas untuk tujuan kredit cukai CBP. Saya bersetuju selanjutnya bahawa jika sebarang tindakan, tuntutan atau prosiding diambil terhadap GETB dan / atau sebarang denda, caj, penalti atau sebarang tanggungjawab CBP dikenakan kepada GETB disebabkan bergantung kepada maklumat tidak benar daripada saya terhadap pendaftaran CBP Pemilik Sijil, saya berjanji untuk tidak menyalahkan GETB dan memastikan GETB dilindungi sepenuhnya seperti dibenarkan undang-undang.

Saya mengisytiharkan bahawa jawapan di atas adalah betul dan benar serta saya bersetuju jika saya membuat atau akan membuat sebarang kenyataan yang tidak tepat atau menahan atau menyembunyikan sebarang fakta material; hak saya / Orang yang Dilindungi untuk menerima pampasan akan dilucutkan dengan mutlak. Saya, Orang yang Dilindungi / Pemilik Sijil / Pihak yang Menuntut dengan ini membenarkan dan memberi kebenaran kepada mana-mana doktor, pengamal perubatan, pakar perubatan, hospital, makmal, pakar bedah, jururawat, kakitangan perubatan, klinik atau syarikat insurans, pengendali takaful atau organisasi lain, institusi atau individu yang mungkin mempunyai sebarang rekod atau pengetahuan berkenaan kesihatan atau sejarah kesihatan saya / Orang yang Dilindungi ("Pemberi Maklumat") bagi menyediakan maklumat tersebut kepada GETB dan penyedia perkhidmatan berdaftar dan / atau pekerjanya bagi memproses tuntutan Takaful saya. Saya, Orang yang Dilindungi / Pemilik Sijil / Pihak yang Menuntut, bagi pihak saya atau mana-mana individu yang mempunyai sebarang tuntutan atau kepentingan dalam mana-mana sijil di bawah ini, mengetepikan semua peruntukan undang-undang atau etika profesional yang melarang mana-mana Pemberi Maklumat daripada mendedahkan sebarang maklumat yang diperlukan semasa memberi perkhidmatan kepada saya dalam kapasiti sebagai seorang profesional.

Saya, Orang yang Dilindungi / Pemilik Sijil / Pihak yang Menuntut, dengan ini memberi kebenaran dan keizinan untuk menolak wang yang perlu dibayar kepada GETB daripada jumlah tuntutan yang boleh dibayar menurut sebarang Sijil di bawah ini, termasuk tetapi tidak terhad kepada sebarang Caruman yang perlu dibayar, manfaat yang telah didahulukan dan/atau pembayaran salah yang dibuat melebihi sebarang amaun tuntutan. Kebenaran ini akan terikat kepada pengganti hak milik dan penerima serah hak tanpa boleh ditarik balik serta kekal sah walaupun selepas saya meninggal dunia atau hilang upaya serta salinan borang ini adalah berkuat kuasa dan sah seperti asal.

Signature of Person Covered
Tandatangan Orang yang Dilindungi

Name *Nama* _____
NRIC No. *No. KP* _____
Date *Tarikh* _____

Signature of the Certificate Owner
Tandatangan Pemilik Sijil
(If different from the Person Covered)
(Jika lain daripada Orang yang Dilindungi)

Name *Nama* _____
NRIC No. *No. KP* _____
Tel. No. *No. Telefon* _____
Address *Alamat* _____
Date *Tarikh* _____

Signature of Witness
Tandatangan Saksi

Name *Nama* _____
NRIC No. *No. KP* _____
Tel. No. *No. Telefon* _____
Address *Alamat* _____
Date *Tarikh* _____

TOTAL & PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT

Certificate No. | | | | | | | | | | | New NRIC No. | | | | | | | - | | | - | | | | |

Certificate No. | | | | | | | | | | | Old NRIC/Birth Certificate/ Passport No. | | | | | | | | | | | | | | | | | | | | | | |

Certificate No. | | | | | | | | | | |

Certificate No. | | | | | | | | | | | Name of Person Covered _____

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted in within the coverage of a Total and Permanent Disability benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any medical report fee incurred in completing this form, it will be borne by claimant)

1. Are you the Person Covered's usual medical attendant? ☐ Yes ☐ No

   If "YES", since what date? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

2. Has the Person Covered previously suffered from or been detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder, pre-malignant condition, cancer or any other significant illnesses?

   ☐ Yes ☐ No

   If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name and Address of Clinic / Hospital

3. (i) Date when Person Covered FIRST consulted you for the illness. (i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

   (ii) Date(s) of subsequent consultation(s) / follow up(s) (ii) _____

4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Person Covered had been experiencing these symptoms.

Symptoms	Date symptoms first presented (dd/mm/yyyy)
(a)	
(b)	

   What is the source of this information?

   ☐ Person Covered

   ☐ Referring doctor

   Name of doctor and hospital / clinic: _____

   ☐ Others, please specify: _____

5. Diagnosis

   (i) Please describe the full and exact diagnosis. (i) _____

   (ii) Date when the illness was FIRST diagnosed (ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

   (iii) Diagnosis was FIRST made by (name of doctor and hospital) (iii) _____

   (iv) Date when Person Covered FIRST became aware of the illness. (iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

   (v) Date when diagnosis was first made to the Person Covered. (v) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

   (vi) What was the exact information conveyed to the Person Covered? (vi) _____

   (vii) What is the underlying cause of the illness for the diagnosis above? (vii) _____

Great Eastern Takaful Berhad (916257-H)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Telephone: +603 4259 8338 Fax: +603 4259 8808 Customer Service Careline: 1 300 13 8338
E-mail: i-greatcare@greateasterntakaful.com Website: www.greateasterntakaful.com

 3825594400

6. (i) Type of investigations / tests done to confirm the diagnosis

(i) _____

(ii) Type of treatments given and his / her response to the treatments.

(ii) _____

7. (i) Person Covered's occupation before disability

(i) _____

(ii) Nature of duties of the occupation in 7 (i)

(ii) _____

(iii) How does the Person Covered's disability prevent him / her from performing the above listed duties of his / her occupation?

(iii) _____

8. Did the Person Covered consult other doctors for this condition or its symptoms BEFORE he / she consulted you?

☐ Yes ☐ No

If "YES", please provide the following:

Name of Doctor	Name of Clinic/Hospital and Address	Date of First Consultation

Question 9 to be completed if disability caused by an accident

9. (i) Is the condition a result of an accident?

(i) ☐ Yes ☐ No

If "YES", please state the date of accident

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(ii) Describe in detail how the accident happened

(ii) _____

(iii) Was the Person Covered under the influence of alcohol / drug at the time of accident?

(iii) ☐ Yes ☐ No

If "YES", please state the blood alcohol content/drug type and quantity consumed.

_____

(iv) Is the condition self-inflicted?

(iv) ☐ Yes ☐ No

If "YES", please provide full details

_____

Please complete the **Question 11 to 20** based on your latest detailed examination at the date in **Question 10.**

10. Last examination / consultation date

☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

11. Please describe fully the nature of the Person Covered's disabilities.

_____

12. Vision (Visual Acuity)

	Right	**Left**
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

13. Hearing

	Right	**Left**
Normal		
Impaired		
Scores based on speech reception threshold	dB	dB

(Supported by an Audiometry results)

Remarks: _____

14. Function of speech

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Remarks: _____

15. Cognitive function

☐ Normal
☐ Poor comprehension
☐ Difficult with logic and reasoning
☐ Memory loss

Remarks: _____

16. General examination findings:

(i) Are there any abnormal movements or abnormal gait? (Please provide full details) (i) _____

(ii) Is there any muscle wasting? (Please provide full details) (ii) _____

(iii) If there are any other significant examination findings, please provide the details. (iii) _____

17. Examination of the Limbs

(i) Please indicate the muscle power of the various joint in the table below with the maximum grade of 5.

Upper Limbs	Right	Left
Shoulder		
Elbow		
Wrist		
Grip		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

Remarks: _____

(ii) Please indicate the Range of Movement of the various joint in the table below.

Upper Limbs	Right	Left
Shoulder		
Elbow		
Wrist		
Finger(s)		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

Remarks: _____

18. Assessment of Activities of Daily Living

Activities of Daily Living	Not Limited	Limited	Incapable
Transfer (Getting in & out of a chair without physical assistance)			
Mobility (Ability to move from room to room without physical assistance)			
Continence (Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene)			
Dressing (Putting on & taking off all necessary items of clothing without assistance of another person)			
Bathing / Washing (Ability to wash in the bath or shower, including getting in & out of bath or shower or wash by any other means without assistance of another person)			
Eating (All task of getting food into the body without assistance of another person)			

19. (i) Is Person Covered's disability progressively worsening, stagnant or recovering?	(i) _____
(ii) Is full recovery expected?	(ii) ☐ Yes ☐ No If "YES", please state approximate period taken for full recovery from now. _____ If "NO", please state the extent of recovery and approximate period taken for the stated extent of recovery from now. _____ _____
(iii) Is Person Covered confined to a home, hospital or other institution that provides constant care and medical attention? If "YES", since what date?	(iii) _____ ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
20. (i) Is the Person Covered able to perform all the normal duties of his / her usual occupation?	(i) ☐ Yes ☐ No If "YES", when is he/she expected to return to his/her usual occupation? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(ii) If he / she is unable to return to his/her usual occupation, is he / she able to engage in any other occupation?	(ii) ☐ Yes ☐ No
(a) What types of occupation can he / she be engaged in?	(a) _____
(b) When is he / she expected to engage in these occupations?	(b) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
21. Is the Person Covered physically or mentally incapacitated from ever continuing in any employment?	☐ Yes ☐ No If "YES", when did such disability commence? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
22. Is the Person Covered certified to be Total and Permanent Disabled?	☐ Yes ☐ No
(i) If "YES", when did the Person Covered certified to be Total and Permanent Disabled?	(i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(ii) If the incapacity of the Person Covered cannot be confirmed upon examination or ascertained at this moment, would you recommend a review of his/her condition in the near future?	(ii) ☐ Yes ☐ No If "YES", when is the next review / examination of the condition scheduled? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

23. Please provide us with any other additional information that will enable the Takaful Operator to assess this claim. Please enclose copies of laboratory test result, if any.

_____

_____

_____

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and that I have answered the above questions are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name: _____

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

LETTER OF AUTHORISATION/CONSENT - To Obtain Further Information

SURAT PEMBERIKUASA/KEBENARAN - Untuk Mendapatkan Maklumat Lanjut

Certificate No. / *No. Sijil*

Certificate No. / *No. Sijil*

Certificate No. / *No. Sijil*

Certificate No. / *No. Sijil*

Certificate No. / *No. Sijil*

New NRIC No. / *No. KP Baru* - -

Old NRIC/BC/Passport No. / *No. KP Lama/Sijil Kelahiran/ Paspot*

Name of Person Covered / *Nama Orang yang Dilindungi* _____

Our Ref: / *Rujukan Kami:* _____

To Whom It May Concern
Kepada Sesiapa Yang Berkenaan

Dear Sir/Madam,
Tuan/Puan,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre, takaful operator, or
Saya dengan ini memberi kuasa dan mengizinkan mana-mana pegawai perubatan, doktor, pakar bedah, klinik, hospital, pusat perubatan, pengendali takaful atau

other organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of
organisasi, institut atau orang perseorangan ("Pemberi Maklumat") yang mungkin mempunyai apa-apa rekod atau mengetahui tentang pekerjaan,

the employment, financial, health or medical history of _____
kewangan, kesihatan atau sejarah perubatan

("the Certificate Owner") and to provide such information to GREAT EASTERN TAKAFUL BERHAD (916257-H) ("the Takaful Operator") or
("Pemilik Sijil") untuk memberi maklumat kepada GREAT EASTERN TAKAFUL BERHAD (916257-H) ("Pengendali Takaful") atau

its authorised agents and/or employees.
mana-mana ejen/kakitangannya yang diberi kuasa.

I expressly waive on behalf of myself and/or as a next-of-kin of the Certificate Owner and for his/her estate all provisions of law or professional
Saya juga tidak ragu-ragu untuk mengetepikan bagi pihak saya dan/atau sebagai waris terdekat Pemilik Sijil dan untuk harta pusakanya segala peruntukan

ethics forbidding the Information Provider(s) from disclosing any such information acquired on the Certificate Owner in a professional and/or client
undang-undang atau etika profesional yang menghalang Pemberi Maklumat daripada memberi maklumat berkenaan mengenai Pemilik Sijil dalam bidang kuasa

capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may arise, in supplying such
sebagai profesional dan/atau pelanggan dan saya juga memberi pelepasan kepada Pemberi Maklumat ejen/kakitangannya daripada apa-apa liabiliti kerana memberi

information requested by the Takaful Operator.
maklumat tersebut kepada Pengendali Takaful.

This authorisation/consent is irrevocable and a copy of it will have the same effect and validity as the original.
Surat pemberikuasa/kebenaran ini adalah muktamad dan salinannya juga memberi hak dan pengesahan yang sama dengan yang asal.

Signature or Thumb Print / *Tandatangan atau Cap Ibu Jari* _____

Name / *Nama* _____

NRIC No / *No KP* _____ Date / *Tarikh* _____

Relationship with the Certificate Owner / *Hubungan dengan Pemilik Sijil* _____

Registration or Admission No. (If hospitalised) / *Pendaftaran atau No. Kemasukan. (Jika masuk hospital)* _____

CLM-GLOAC-V04-032016-TAKAFUL

DIRECT CREDIT FACILITY FORM

Important

1. By signing this form, you confirm that you have read, understood and agree to the authorisations and declarations printed overleaf.
2. This Direct Credit facility is only available for direct credit to accounts maintained in banks participating in the Interbank Giro (IBG) payment system in Malaysia. In relation to a Payee* who is a minor, payments shall only be made to accounts maintained by the parent or lawful guardian.
3. This Direct Credit facility is not allowed for any joint bank accounts unless the Certificate Owner/Payee is the primary account holder.
4. We reserve the right to release payment by cheque in the event of (a) insufficient / invalid / incorrect information being provided in this Direct Credit facility form, (b) payment being made to joint Payees (e.g. joint administrators or joint executors), and / or (c) the failure of the transfer to the beneficiary bank for any reason whatsoever, (d) If the claim amount exceeds the maximum amount allowed by IBG transaction.
5. All further claims benefits payable for the same event will be credited into the account below, unless otherwise notified by the certificate owner.

Payee* refers to any person / company who is the person entitled to the Certificate monies, e.g. Certificate owner, Person Covered, beneficiary, assignee, trustee, Public Trustee / Amanah Raya, executor / executrix, administrator / administratrix.

Certificate No.

Name of Certificate Owner / Payee*

Name of Person Covered (applicable for claims if different from above)

NRIC No. / Passport No. / Company Registration No. ** same as in Certificate and Bank Account*

Beneficiary Bank

Bank Account Holder Full Name

Bank Account No.

Account Type ☐ Single Account ☐ Joint Account *(Only allowed if Certificate Owner / Payee is the primary account holder)*

Transaction Type ☐ Cash Payout ☐ Surrender/Withrawal ☐ Cash Benefit ☐ Maturity ☐ Contribution Refund ☐ Family Claims ☐ Individual Health Claims ☐ Others_____

Email Address (mandatory)

Mobile (mandatory) + *Country Code* 6 0 1 2 3 4 5 6 7 8 9

example: 012-345 6789 (Malaysia)

** The mobile and email address REQUIRED will be used for payment notification for the above certificate(s)*

AUTHORISATION / DECLARATION

I / We hereby:

1. Instruct the Takaful Operator to pay into my / our designated bank account ("Account") as stated overleaf all the amount payable to me / us arising from transactions effected through the above Certificate.

2. Declare that the information provided by me / us as in this form are true and correct and undertake to immediately inform the Takaful Operator any change in the same.I further confirm that I am the Account holder and have full power and authority to operate the Account [*in respect of a partnership or a body corporate*]. We further confirm that the person signing this form is the authorised signatory for the Account, and have full power and authority to operate the Account.

3. Understand that this standing instruction shall not take effect on any existing transactions that have already been executed and that the Takaful Operator has the right to reject this standing instruction in the event that it is found to be payable to a third party account.

4. Agree that the Takaful Operator shall not be liable in the event that any payment transaction into my / our Account is delayed or cannot be effected due to incorrect or incomplete information being provided in this form, and / or for any other reason beyond the reasonable control of the Takaful Operator.

5. Acknowledge and agree that the payment made into the Account shall be a valid discharge of the Takaful Operator's liability under the Certificate. I / We further agree that the Takaful Operator shall not be held liable for any damages, losses, claims, cost and / or expenses which I / we may incur as a result of such payments made into the Account in accordance with my / our instructions herein, including but not limited to the subsequent withdrawal of the Certificate monies from the Account by persons other than myself / ourselves, and agree to indemnify and to keep the Takaful Operator indemnified of any damages, losses, claims, cost and / or expenses incurred by the Takaful Operator in defending any claim arising from and / or in connection with payments made by the Takaful Operator into the Account in accordance with my / our instructions herein.

Great Eastern Takaful Berhad (916257-H)
Head Office: Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Customer Service Careline: 1 300 13 8338 Fax: +603 4259 8808
E-mail: i-greatcare@greateasterntakaful.com Website: www.greateasterntakaful.com

 6256357453

6. Agree to immediately refund to the Takaful Operator in full any monies paid into the Account which is paid in error or which I am / we are otherwise not entitled to receive.

7. Declare that I am not an undischarged bankrupt [*in respect of a partnership or a body corporate*]. We declare that no order has been made, petition filed or resolution passed for our winding up, dissolution or liquidation or for the appointment of a liquidator, receiver, custodian or trustee for all or any part of our property or assets or for an administration order against us.

8. Agree that this instruction shall continue to be in force until I / we expressly revoke the same by executing a new Direct Credit facility form to replace this Account with a new bank account. However, the Takaful Operator may in its absolute discretion terminate the Direct Credit service at anytime and without assigning any reason(s) therefor.

9. Agree that the personal data provided in this form may be recorded, used, disclosed, processed and stored by the Takaful Operator for the purposes relating to the payment of funds in accordance with my / our instructions herein, and for the purposes of compliance with any legal or regulatory requirements.

10. Consent that my personal information may be used, recorded, stored, disclosed or otherwise processed by or on behalf of the Takaful Operator (and its successors in title) to carry out takaful business.

Signature of Payee* & Company Stamp (if applicable)

Name: _____

Date: _____ *(DD/MM/YY)*

For Office Use:

Bank Code: | | | | | | |

Branch Code: | | | | | | |

Reject Reason: _____

Signature of Witness

Name: _____

NRIC No: _____

Contact No: _____

Address: _____