GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD
40 & 44 Jalan Ampang, 50450 Kuala Lumpur
Claims Department Tel. No: 2003768/2003788 Fax No. : 2387085

DEATH CLAIM FORM

1. Policy Number & Description
   (i) .... (ii) ....
   (iii) .... (iv) ....

2. Name of the Assured (Deceased) in full.	
3. Last address of the Deceased.	
4. Details of last employment / business : i) Address of employer / business ii) Nature of business / employment / work	
5. Cause of death ☐ Tick this box if cause of death is unknown	
What is your relationship with the Deceased? *Proof of relationship is required for non-Muslims claiming in the capacity as a spouse, child or parent nominee under a trust policy and for *ALL CLAIMANTS* claiming on a policy without *NOMINATION*. Was the Deceased married? ☐ Yes ☐ No Was the Deceased a *Muslim*[#] at death? ☐ Yes ☐ No	☐ Assignee (Please submit your Original Deed of Assignment) ☐ Legal owner (Third Party policy) ☐ Spouse ☐ Child of the Deceased ☐ Parent of the Deceased What family has the Deceased left? ☐ Spouse ☐ Child ☐ Others. Please specify __________ [#]*Nominee of a Muslim Deceased shall distribute the policy moneys in accordance with Islamic law.*
7. Has the Deceased any other insurance with other insurers? ☐ Yes ☐ No	Policy No. Company
8. Where/how do you wish to receive your claim payment?	☐ Central Office ☐ Through the Agent (Please fill in a letter of authority) ☐ Agency/Branch Office __________ ☐ Through Registered Mail
9. Is there a servicing agent assisting you in the claim? *This form is issued free of charge and no commission is payable to any agent or employees of the Company is respect of making a claim.*	☐ Yes ☐ No - if yes, please give the agent's full name & address.
). Death Due To Illness/Natural Death	To the best of your knowledge :
a) When did the Deceased first complain of, or give other indication of his/her last illness?	a)
b) When did the Deceased first consult a doctor for his/her last illness?	b)
c) Please state the names and addresses of the doctors who attended to the Deceased during his/her last illness?	c)
d) Smoking? ☐ Yes ☐ No	

e) Names & addresses of all doctors / hospitals who attended the Deceased during the last two years prior to death ?

Name	Address	Dates of Attendance	Diagnosis

11. Death Due To Accident	(Only required to be completed if the cause of death was due to an accident)
a) Date & Time of accident?	
b) Place of accident?	
c) What was the Deceased doing?	
d) Describe in detail how the accident happened?	
e) Was the accident reported to the Police?	☐ Yes ☐ No If reported, please submit a certified copy of the report.
f) Was the accident reported in the newspaper?	☐ Yes ☐ No If reported, please submit a copy of the newspaper reportage.
g) Was a post-mortem carried out?	☐ Yes ☐ No

A Post-Mortem report and an Accidental Death Benefits Claim form are required if you are entitled to claim for additional accidental death benefits under the policy.

I declare that all answers given by me in this claim form are, to the best of my knowledge and belief, true and complete. I also consent to the Company to seek further information from any medical practitioners, hospitals or clinics attended by the Deceased or the Deceased's previous employer(s) or from any insurer(s) to which a proposal for insurance has been made on or by the Deceased and I authorise the same the giving of such information.

I further agree that the furnishing of this claim form or any other supplemental forms by the Company will not be considered an admission that there was any insurance in force on the life of the Deceased with the Company nor be deemed a waiver of the Company's rights or defences.

Claimant's Signature ....
NRIC No. ....
Name ....
Tel No. ....

Address ....
....
....
....

LETTER OF AUTHORISATION / CONSENT
To Obtain Further Information

To Whom It May Concern

Dear Sir/Madam,

I hereby authorise and give my consent to any medical practitioner, physician, surgeon, clinic, hospital, medical centre insurance company or other organisation, institution or individual concerned ("the Information Provider(s)") that may have any records or knowledge of the employment, financial, health or medical history of ______________________ ("the Assured") and to provide such information to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)("the Company") or its authorised agents and/or employees.

I expressly waive on behalf of myself and/or as a next-of-kin of the Assured and for his/her estate all provisions of law or professional ethics forbidding the Information Provider(s) from disclosing any such information acquired on the Assured in a professional and/or client capacity and I further release the Information Provider(s) and its agent/staff from any liability whatsoever that may arise, in supplying such information requested by the Company.

This authorisation / consent is irrevocable and a copy of it will have the same effect and validity as the original.

____
Signature or thumb print
NRIC No. ______________________
Date ______________________

Name ______________________
Relationship with Deceased ______________________