# Total and Permanent Disability Benefits Claim Form
## ( to be completed by the Assured)

| | |
|---|---|
| 1. Name:<br>New NRIC :<br>Old Nric : | 2. Policy Numbers : |
| 3. Address:<br><br>Postcode: Telephone: | 4. Business Address:<br><br>Postcode: Telephone: |
| 5. What is the highest level of education do you have ?(primary,secondary, diploma,degree,post graduate) | 6. Are you currently confined to bed / house / hospital. |
| 7. When were you last able to work? | 8. State the date when you are expected to resume your work and daily activities. |
| 9. Are you entitled for compensation from other Insurer or any sources. Please provide details. Provide certified copies of the offer letter.<br>Policy/Refn.No Name of Sources | 10. If your service is terminated, please confirm the effective date and **provide copy of the termination letter** |

PARTICULARS OF OCCUPATION

11. Please list the jobs held in the past 3 years:

| Dates (From -To) | Job Title & Employer's Address | Exact Duties of Work | Average monthly Income (Rm) |
|---|---|---|---|
| | | | |

12.PARTICULARS OF YOUR CURRENT EMPLOYMENT

| WORK AREA | JOB SKILLS |
|---|---|
| a)What kind of environment do you work in? (office,factory,etc) | a)What is the qualification and/or skillsneeded for the job? |
| b)Are you in management or supervisory capacity? | b) Any special skills required? |
| c) Do you operate any machinery or special equipments? | c)What level of practical experience is required? |

**NOTE : No liability is admitted by issuing this claim form**

CLM/FORMS/TPD/2000/00

| TRAVEL& BUSINESS HOURS | |
|---|---|
| a)What is your normal working hours and days?<br><br>b) Are you required to work on shift,Sunday or on-call?<br><br>c)How do you go to work?<br><br>d)What is the distance of travel to go to your normal place of work? | Does your work require you to:<br><br>1. Driving a car?<br>2. Driving other vehicles?<br>3.Climbing ladders or heights?<br>4.Carrying heavy loads?<br>5.Lifting heavy loads<br>6.Crawling or kneeling?<br>7. Other physical exertions?<br>8. Travelling away from your normal place of work? |

| 13. TO BE COMPLETED BY A SELF-EMPLOYED PERSON ONLY | |
|---|---|
| a) Please name your business/Company<br><br>c) Are there any other proprietors or directors of the business? How many? | b) What is the nature of your business?<br><br>d)Please provide your business registration number and your Company registration number, if incorporated |

| 14.TO BE COMPLETED IF DISABILITY CAUSED BY AN ACCIDENT | |
|---|---|
| a) When did the accident happen?<br>Date:<br>Time: am/pm<br>Where: | b) Describe in detail how the accident happened. |
| c) Please provide the police report number and a copy of it and details of any witness. | d)Describe the extent of the injuries sustained in the accident. |

| 15.TO BE COMPLETED IF DISABILITY CAUSED BY AN ILLNESS | |
|---|---|
| a) Please fully describe the condition or the symptoms. | b) When did the symptoms/condition first appear? |
| c)What is the exact diagnosis and when was it made known to you? | d) Provide the name and address of the doctor who had made the diagnosis? |

| e) What tests or investigations were done to confirm the diagnosis? | f) What are the treatments you undergoing currently? |
|---|---|

g) 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,addresss and when)

**THIS SECTION MUST BE FULLY COMPLETED**

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DETAILS OF DOCTORS YOU HAVE CONSULTED PRIOR TO THE DISABILITY

| Name | Address | Date of Consultation | Reason for Consultation |
|---|---|---|---|
| | | | |

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DETAILS OF DOCTORS YOU HAVE CONSULTED SINCE THE DISABILITY

| Name | Address | Date of Consultation | Reason for Consultation |
|---|---|---|---|
| | | | |

## DECLARATION BY THE ASSURED / LIFE-TO-BE ASSURED

I declare the above answers are true and correct. I also consent the Company in seeking information regarding myself from any doctor, hospital, insurance companies,employer and any organisation and authorise in giving such information. A photocopy of this document deem to be accepted as a true consent letter .

I understand that The Great Eastern Life will not be deemed to have admit the liability of the claim by issuing the form and investigating my claim or accepting evidence of my claim.

.....
Signature of Witness:

Identity Card No :
Name:
Contact No :
Address:

.....
Signature of the Life Assured:

.....
Signature of the Assured
(if different life from the Life Assured)

Identity Card No :
Contact No :
Address:

**Note:** All photocopies of the documents submitted must be certified by a person of prominent standing such as our Company authorised officers, doctors, Magistrate, Ketua Balai Polis, Comnisioner for Oath, Public Notary or Aadvocate & Solicitor.

I wish to receive the claim cheque* by :

Post ☐

Collected by third party ☐

(please give an authorised letter to the third party for every payment)

Name of the third party:
Contact Number :

* subject to admission of liability by the Company