CLAIM FORM FOR OUTPATIENT CLINICAL & DENTAL BENEFIT
BORANG TUNTUTAN RAWATAN PESAKIT LUAR & PERGIGIAN POLISI BERKELOMPOK

Great Eastern
An OCBC Company

Policy No.: *No. Polisi*	Claimant's NRIC/Passport No.: *KP Baru/Paspot Penuntut*
	Handphone No.: *No Telefon Bimbit*
☐ Outpatient Clinical *Rawatan Pesakit Luar*	Name of Patient: *Nama Pesakit*
☐ Dental *Pergigian*	Name of Member/Employee: *Nama Ahli / Pekerja*
	Name of Employer: *Nama Majikan*

PART A : OUTPATIENT CLINICAL *BAHAGIAN A : RAWATAN PESAKIT LUAR*

No	Questionnaires
1	When and what time the treatment was sought? *Bila dan pukul berapa anda mendapatkan rawatan?* Date: *Tarikh* _____ Day: *Hari* _____ Time: *Masa* _____
2	At which clinic did you seek treatment? *Anda mendapatkan rawatan di klinik mana?* Name of Clinic: *Nama Klinik* _____ Address: *Alamat* _____ Name of doctor: *Nama Doktor* _____ Address: *Alamat* _____
3	Reason for seeking treatment at Non Panel Clinic *Alasan mendapatkan rawatan di klinik non panel* _____
4	What was the diagnosis? *Apa penyakitnya?* ☐ Acute Gastroenteritis / *Radang dalam perut* ☐ Asthma / *Lelah* ☐ Backache, Joint pains / *Sakit belakang, sakit sendi* ☐ Burns & Scalds / *Terbakar & melecur* ☐ Ear, Eye infection / *Jangkitan telinga, mata* ☐ Diabetes / *Kencing manis* ☐ Gynecology problems / *Sakit puan* ☐ Gastritis / *Gastrik* ☐ Headache, Migrain / *Sakit kepala, Migrain* ☐ Dermatitis, Skin problems / *Masalah kulit* ☐ Hypertension / *Tekanan darah tinggi* ☐ Injuries, Cuts / *Luka* ☐ Pregnancy, Obstetric / *Kehamilan, obsterterik* ☐ Antenatal, Postnatal / *Penjagaan sebelum atau selepas bersalin* ☐ URTI, Flu, Sore Throat / *URTI, selsema, sakit kerongkong* ☐ Viral fever / *Deman virus* ☐ Immunization / *Imunisasi* ☐ Others (please specify) / *Lain-lain (sila nyatakan)* _____
5	Medication given *Ubatan* — Day(s) of medical leave *Cuti sakit*
6	Procedure *Prosedur* — Amount of medical bill (Please attach original receipt) *Amaun yang dicajkan (Sila sertakan resit asal)* RM _____

PART B : DENTAL *BAHAGIAN B : PERGIGIAN*

Name of Clinic: *Nama Klinik Pergigian*	Address of Clinic: *Alamat Klinik*
Name of Dentist: *Nama Doktor Pergigian*	
Amount Incurred (Please attach original receipt): *Amaun yang dicajkan (Sila sertakan resit asal)*	

Services Rendered (please tick whichever is applicable) *Servis disediakan (Sila pilih mana yang berkenaan)*

☐ Oral Examination *Pemeriksaan Mulut*
☐ Extraction *Cabutan*
☐ Filing *Tampalan*
☐ Medication *Ubatan*
☐ Others (Please specify) *Lain-lain (Sila nyatakan)* _____

I declare that all the above information is true and valid. I hereby authorize the Company to verify from whatever sources the Company deemed appropriate. I also hereby authorize the clinic to release my medical information including the history to the Company.
Saya mengisytiharkan semua maklumat di atas adalah benar dan sah. Saya memberikan kuasa kepada Syarikat untuk mengesahkan sebarang maklumat yang diperlukan. Saya juga memberikan kuasa kepada klinik untuk mendedahkan sebarang maklumat termasuk maklumat perubatan saya yang lalu.

Signature of Employee *Tandatangan Pekerja*	Signature of Employer & Company Stamp *Tandatangan & Cop Syarikat*	Signature of Patient (*) *Tandatangan Pesakit*
Date: *Tarikh*	Date: *Tarikh*	Date: *Tarikh*

(*) The employee should sign if the patient is a dependent child. *Pekerja harus menandatangani borang ini jika pesakit ialah kanak-kanak.*

HSD-OPCDF-V01-082025a

Great Eastern Life Assurance (Malaysia) Berhad (93745-A)
Medical Claims Department, Level 4, Menara Great Eastern 303 Jalan Ampang 50450 Kuala Lumpur
Contact Centre Hotline: 1-300-1-300-18
E-mail: healthcareservices@greateasternlife.com Website: www.greateasternlife.com

2116633990