Great Eastern General Insurance (Malaysia) Berhad (102249-P)
(Formerly known as Overseas Assurance Corporation (Malaysia) Berhad)
Level 18, Menara Great Eastern, 303, Jalan Ampang, 50450 Kuala Lumpur
General Line: +603 4259 8888 Fax: +603 4813 0055
Customer Service Careline: 1300-1300 88
Website: www.greateasterngeneral.com

Great Eastern
A member of the OCBC Group

TRAVEL CLAIM FORM

Please submit the duly completed Travel Claim Form with the documents required to expedite claim processing.

The Travel Document Checklist is available at our corporate website at www.greateasterngeneral.com

The furnishing and/ or acceptance of this form shall not be regarded as a waiver by the Company of its rights and the Company makes no admission of liability on the part of the Company.

GENERAL INFORMATION (to be completed for all claims)

Policy number: ______________________________

Insured person's full name: ______________________________

Correspondence address: ______________________________
____

Mobile number: ______________________________

Email address: ______________________________

PERSONAL ACCIDENT/ MEDICAL EXPENSES/ HOSPITAL ALLOWANCE

1. State nature of illness/ injury: ______________________________
2. Date/ place of accident/ onset of illness: ______________________________
3. Date and time of admission: ______________________________ Date and time of discharge: ______________________________
4. Have you ever suffered this or a similar condition or a recurrence of previous illness or injury? If yes, give full details:
____
____
5. Give name and address of your usual attending physician ______________________________
____
____

TRAVEL DELAY/ REROUTE/ OVERBOOKED/ MISCONNECTION/ MISSED DEPARTURE

1. Reason for delay/ reroute/ overbooked/ misconnection/ missed departure: ______________________________
____

2a. Scheduled departure date and time: ______________________________
2b. Actual departure date and time: ______________________________
2c. Scheduled arrival date and time: ______________________________
2d. Actual arrival date and time: ______________________________
2e. Alternative flight departure date and time: ______________________________

3. For missed departure, please list below amount being claimed:

Charges incurred	Refunds obtained	Amount claimed after refund

TRAVEL CANCELLATION/ CURTAILMENT/ POSTPONEMENT

1. When was holiday booked? ______________________________
2. Intended departure date: ______________________________
3. Date cancelled: ______________________________
4. Why was trip cancelled? ______________________________
5. Amount paid by you ______________________________
6. Amount claimed ______________________________

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BAGGAGE & PERSONAL EFFECTS (LOSS/ DAMAGE/ DELAY)/ LOSS OF MONEY/ TRAVEL DOCUMENT

1. State date of loss/ damage: ______________________ Place of damage: ______________________
2. Name of Carrier involved: ______________________
3. State full details in which loss/ damage occurred: ______________________
____
____
____
____
4. To whom did you report the accident/ loss to: ______________________
5. Please provide date of report and report no. : ______________________
6. Are you claiming under any other insurance? If yes, please provide details:
____
7. For baggage delay,
From date/ time: ______________________ To date/ time: ______________________

Please list below all items lost/ damaged/ newly purchased to which you are claiming:

Item	Description	Year of purchase	Cost of purchase

For loss of money, please provide:

Amount in foreign currency	Amount in RM	Total amount claimed

For loss of personal documents, please list below the expenses incurred:

Date	Description of expenses

PERSONAL LIABILITY

1. State nature of injury/ damage caused: ______________________
2. Date, time and place of occurrence: ______________________
3. Circumstances of the incident: ______________________
____
____
4. Name and address of Third Party involved: ______________________
____
5. Name and address of witness: ______________________
____
6. Were details taken by or reported to the Police? Please provide the date of report and report no.
____

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OTHERS

1. State date of incident: ______________________________
2. State benefit(s) claiming: ______________________________
3. Please provide detailed circumstances of loss: ______________________________
____
4. Others: ______________________________
____

DATA PROTECTION NOTICE

By submitting this form, you are providing personal information to the Company. The Company will be processing your personal information provided in this form and/ or further information and data that may be required by the Company either from you or from any third parties. Your personal information may be used, recorded, stored, disclosed or otherwise processed by or on behalf of the Company (and its successors in title) for the purpose of (i) processing your claim or investigation or analysis of such claim; and (ii) ascertaining your claims history in order to improve claims processing and prevent fraudulent claims. By submitting this form, you consent and authorize the Company to obtain and verify any information about you from you or from any third parties which the Company may require in connection with your claim. Such consent and authorization herein shall extend to any information obtained from any of the insurance policy(ies) presently provided to you, any new application to the Company for insurance, such historical financial or credit records, data or information whether or not provided personally. The information that you have provided to the Company is necessary. If you do not provide the Company with such information, the Company may not be able to respond to your claim. The Company may disclose and/ or provide your personal information to the Company's Authorised Representative or any other third party, necessary for the processing of your claim. You may access certain personal information held by the Company based on the applicable data protection laws of Malaysia. You may access your personal information during office hours by calling Customer Service Care at 1300- 1300 88. If you have any inquiry or complaint (such as limiting the processing of certain information), you may contact our Customer Service Care at 1300- 1300 88, or write to the Company. The Company may charge a reasonable fee for access. If you can show that the personal information held by the Company is not accurate, complete and up to date, the Company will take reasonable steps to ensure it is accurate, complete and up to date upon receiving your verification/ feedback. For more information on how the Company deals with your personal information please log on to www.greateasterngeneral.com and read the Company's Client Charter and Privacy Policy or contact the Company's Authorised Representative for a copy.

DECLARATION

I, the Insured Person/ Claimant, 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/ the Insured Persons's right to be compensated shall be absolutely forfeited. I, the Insured Person/ Claimant, hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organisation, institutions or persons that may have any records or knowledge of my/ the Insured Person's health or medical history ("Information Provider"), to provide such information to Overseas Assurance Corporation (Malaysia) Berhad (102249-P) ("the Company") and its authorised service provider and/ or its employees in order to process my insurance claim. I, the Insured Person/ Claimant, expressly waive on behalf of myself or any other person who shall have any claim or interest in any policy 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. A copy of this form shall be effective and valid as the original.

____
Signature of Insured person/ Claimant
(For Group Policyholder, please also affix the Group Policyholder's Company rubber stamp)

Name :
NRIC No. :
Date :

____
Signature of Witness

Name :
NRIC No. :
Date :