CARESHIELD / ELDERSHIELD CLAIMANT'S STATEMENT

Important Note:

1 The Great Eastern Life Assurance Company is hereby referred to as "The Company".
2 To be completed by the Policyholder. Date format in dd/mm/yyyy. Submit this together with relevant tests.
3 All eligible policies will be processed together.
4 Please ensure your contact details with the Company, including mobile no. and email address are updated to receive your correspondences.

* Please tick where appropriate.

1 Details of Policyholder / Life Assured

Full Name: _____ NRIC / Passport No.(for foreigner only): | | | | | | | | | | | | |

Are you a GST-registered person at the effective or renewal date (whichever is later) of the Careshield / Eldershield policy? ☐ Yes ☐ No

Full Name of Life Assured (if different from Policyholder): _____ NRIC / Passport No.(for foreigner only): | | | | | | | | | | | | |

Contact Number: (Home) _____ (Mobile) _____

Address: _____

2 Details of Child (For policy with Dependant Care Benefit for Child below 22 years old as at Claim Date)

Full Name: _____ NRIC / Birth Certificate ("BC") No. of Child | | | | | | | | | | | | |

Date of Birth (dd/mm/yyyy): _____

Date of Adoption (dd/mm/yyyy): _____ ☐ Not Applicable

Note: Please provide a copy of NRIC/BC of the Child, and legal adoption document (if applicable).

3 Details of Claim and Medical Consultation History

a) Date symptoms first appeared: _____
Describe symptoms in full: _____
Details of accident, if applicable: _____

b) Date first consulted a doctor: _____
Name and Address of Doctor: _____
Treatment and Advice given: _____

c) Date condition first diagnosed: _____
Full and exact diagnosis: _____
Name and Address of Doctor: _____

d) Details of other doctors whom the Life Assured consulted for this condition (or similar condition is the past):

Date of Consultation	Diagnosis	Name & Address of Doctor Consulted

e) Does the Life Assured suffer from any other medical condition or disability? ☐ Yes ☐ No

If "YES", please give details.

Date First Diagnosed	Medical Condition/Disability	Name & Address of Doctor Consulted

4 Other Insurance

Is the Life Assured insured with other insurance company? ☐ Yes ☐ No

If "Yes", please give details.

Date of Issue	Name of Insurer	Type of Plan	Sum Assured (S$)	Claim Notified

Signature of Claimant _____ Date _____

5 Settlement Option - Please do not leave blank and tick one option.

☐ **PayNow up to S$200,000**

By selecting this option, I confirm that I have registered with PayNow and I have linked my Singapore NRIC to my bank account ("PayNow Account") whereby I am the Legal and Beneficial Owner of the PayNow Account. I hereby authorise and instruct The Company to deposit the payment that is payable to me into my PayNow Account as well as to verify my PayNow Account with the respective Bank (where necessary). In the event that the PayNow transaction is unsuccessful, I agree and acknowledge that a cheque for the payment will be issued to me.

☐ **Direct Credit up to S$10,000**

By selecting this option, I confirm that I have provided a copy of my recently issued bank statement / passbook / e-statement showing your full name, ID / address, bank name, branch and account number (with transaction and other
details blanked out) for verification purpose. For the payment to third party (family member/caregiver), I have attached the completed Letter of Undertaking & Indemnity and a copy of the recently issued bank statement / passbook / e-

Name of Bank Account Holder	**Bank Account No.**
Name of Bank	**Name of Branch**

DECLARATION

Note: If the claimant has previously been assessed by a doctor to lack mental capacity*, the claimant's appointed donee(s)/deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incapacitated claimant need not sign off/affix thumbprint.

*A separate doctor's memo should be submitted to indicate that the claimant lack mental capacity, including the relevant medical reason(s).

1. I/We, declared that I/We am/are not an undischarged bankrupt or insolvent or has/have executed any deed or transfer for the benefit of creditor within the last twelve (12) months.

2. I hereby declare that the information, answers and statements provided above are in every respect true, complete and correct, and that no material information has been withheld nor is any relevant circumstances omitted.

3. I hereby agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to process and administer my claims.

These purposes are set out in Great Eastern's Privacy Statement, which is accessible at *http://greateasternlife.com/sg/en/privacy-and-security-policy.html* and which I confirm I have read and understood, including without limitation:

(i) the Companies, their representatives, agents, authorised service providers and other relevant third parties ("Requesting Parties") may collect medical information concerning me from any persons possessing the same (such as doctors whom I have consulted), and I hereby authorise those persons to release the same to any of the Requesting Parties for the purpose of my claims, and

(ii) the Requesting Parties may disclose any relevant information concerning me (including my medical information) to other parties, which any of the Requesting Parties deems necessary for the purpose of my claims.

I further agree that this declaration shall form part of my proposed application for ElderShield Supplements or GREAT CareShield benefits, agree Great Eastern's Privacy Statement and a copy of this form treated as valid and binding as if it were the original.

Name of Applicant	NRIC No.	Signature/Thumb Print of Applicant	Date

To be completed if form is filled up by family members / caregiver	
Name of family member / caregiver*	Signature of family member / caregiver*
Relationship to Applicant	Date
Address	Contact Number

The Manager
Claims Department

The Great Eastern Life Assurance Company Limited
1 Pickering Street #01-01
Great Eastern Centre
Singapore 048659

Policy No. _____

PART I: LETTER OF UNDERTAKING & INDEMNITY

I / We declare that I am / We are the main caregiver of the Policyholder _____
(Name of Policyholder) of NRIC No. _____, Policy No (s): _____

In consideration of The Company agreeing or having agreed, at the Policyholder's / my / our request to pay the benefits, which the Policyholder is entitled to under the ElderShield Supplements / GREAT CareShield policy ("Benefits"), to me / us, I / We agree and undertake as follows:-

1. That I / We will first use the Benefits paid by The Company for the Policyholder's care
2. That I / We will inform The Company immediately upon becoming aware that the Policyholder recovers from the disability, or passes away.
3. That I / We repay any Benefits, which the Policyholder is not entitled or ceases to be entitled to, upon written demand by The Company. I / We agree and undertake that if I / We fail to make such repayment, I / We will fully indemnify The Company against any loss, damage, cost and expenses whatsoever, including any legal cost, which may be incurred by The Company as a result of my / our failing to fully repay the Benefits or of The Company's need to enforce its rights under the Undertaking or Indemnity.
4. I / We hereby declare that the information, answers and statements provided above are in every respect true, complete and correct, and that no material information has been withheld nor is any relevant circumstances omitted.
5. I / We hereby confirm and represent to The Company that I / We have the authority to provide consent on behalf of the Policyholder.
6. I / We hereby agree and consent to The Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my / our / the Policyholder's personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to process and administer the Policyholder's claims.
7. These purposes are set out in Great Eastern's Privacy Statement, which is accessible at *http://greateasternlife.com/sg/en/privacy-and-security-policy.html* and which I/We confirm I/We have read and understood, including without limitation:
   (i) the Companies, their representatives, agents, authorised service providers and other relevant third parties ("Requesting Parties") may collect medical information concerning me from any persons possessing the same (such as doctors whom I have consulted), and I hereby authorise those persons to release the same to any of the Requesting Parties for the purpose of my claims, and
   (ii) the Requesting Parties may disclose any relevant information concerning me (including my medical information) to other parties, which any of the Requesting Parties deems necessary for the purpose of my claims.
8. I / We further agree that this declaration shall form part of / our / the Policyholder's proposed application for Benefits, and a copy of this form shall be treated as valid and binding as if it were the original.

"The Company" refers to The Great Eastern Life Assurance Company Limited.

PART II: DIRECT CREDIT AUTHORISATION

Please provide a copy of your recently issued bank statement / passbook / e-statement showing your full name, ID / address, bank name, branch and account number (with transaction and other details blanked out) for verification.

I / We hereby authorise The Company to credit the Benefits that are payable to the policyholder under the Benefits into this account and verify my account with the bank.

Name of Bank Account Holder(s)	NRIC No.
Name of Bank	Name of Branch
Bank Account Number	

For Homes / Institutions ONLY (if benefits are to be made to the Home / Institution)	
Name of Authorised Officer	Official Stamp of Home / Institution
Signature & Date	

To be completed if form is filled up by family members / caregiver	
Name of family member / caregiver*	Signature of family member / caregiver*
Relationship to Applicant	Date
Address	Contact Number

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