

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. Submit this together with relevant tests.
 - 3 All eligible policies will be processed together. Date format in **dd/mm/yyyy**.
 - 4 Please ensure your contact details with the Company, including mobile no. and email address are updated to receive your correspondences.
- *Please delete or circle where appropriate.

1 Details of Policyholder / Life Assured

Full Name: _____

NRIC No. / Passport No. / FIN No.:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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 No. / Passport No. / FIN No.:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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): _____

Applicable / 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

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659



CCLM

greatasteasternlife.com

For enquiries, call (65) 6248 2888 or visit us at greatasteasternlife > Contact Us

Aug 2025

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

By selecting this option, I confirm that I have registered with PayNow and I have linked my Singapore NRIC/FIN 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). This is applicable to SGD denominated policies only.

☐**Direct Credit Option**

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-statement with the above details for the third party.

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. / Passport No. / FIN 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 Great Eastern Life Assurance Company Limited

1 Pickering Street #01-01
Great Eastern Centre
Singapore 048659

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. / Passport No. / FIN 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.

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659

For enquiries, call (65) 6248 2888 or visit us at greateasternlife.com > Contact Us



CCLM

greateasternlife.com

Aug 2025

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. / Passport No. / FIN No.:
Name of Bank	Name of Branch
Bank Account Number	

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

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

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

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659

For enquiries, call (65) 6248 2888 or visit us at [greateasternlife](http://greateasternlife.com) > Contact Us



CCLM

greateasternlife.com

Aug 2025