



(b) Describe fully the symptoms for which the Life Assured consulted a doctor.

---

---

(c) How long did the Life Assured have the symptoms before he/ she consulted a doctor?

---

---

(d) Date when the Life Assured FIRST consulted a doctor:

Day		Month		Year	

(e) Name and address of the doctor whom the Life Assured first consulted for the illness or injury:

---

---

(f) If consultation was for illness, describe fully the extent and nature of the Life Assured's illness.

---

---

(g) If consultation was due to an accident, describe fully the nature of the Life Assured's injuries and how it happened.

---

---

(h) Has the Life Assured previously suffered from or received treatment for a similar or related illness?

YES / NO\*

If "YES", please give full details.

---

---

(i) Does the Life Assured suffer from any other medical condition?

YES / NO\*

If "YES", please give details:

Description of Medical Condition	Date(s) Diagnosed (DD/MM/YY)	Name and Address of Attending Doctor(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policyholder

**5 RECORD OF MEDICAL CONSULTATIONS**

(a) Provide the details of any doctors who have been consulted in connection with the Life Assured's illness:

Name(s)	Name(s) of Clinic(s)/ Hospital(s) and Address	Date(s) of First Consultation

(b) Provide the name(s) and address(es) of the Life Assured's regular doctor(s).

Name(s)	Address(es)	Date(s) of Consultation (DD/MM/YY)	Reason(s) for Consultation

**6 OTHER INFORMATION**

Has the Life Assured or the Claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy? YES / NO\*

**7 OTHER INSURANCE**

Is the Life Assured claiming from any other insurance company or other sources in respect of this illness/ injury? YES / NO\*  
If "YES", provide the following information.

Name of Insurer	Date of Issue	Sum Assured	Type of Plan	Claim Amount	Claim Notified (YES/ NO)	Claim Paid (YES/ NO)

**8 MODE OF CLAIMS PAYMENT** (Please Tick)☐ **Please credit my proceeds via PayNow.**

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 Great Eastern Life Assurance Company Limited ("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, the Policyholder.

Note: PayNow will only be applicable for claims up to S\$200,000 and payable to Policyholder's local bank account.

☐ **Quick Cheque Deposit.**

I wish to request for Quick Cheque Deposit and enclosed a copy of my (PolicyHolder) bank statement or bank book for verification. I hereby authorise and instruct The Great Eastern Life Assurance Company Limited ("Company") to deposit the cheque to the quick cheque deposit slot of the designated bank stated in my bank statement or bank book.

☐ **Cheque Payment.**

I wish to request for Cheque payment. I agree and acknowledge that a cheque for the payment will be issued to me, the Policyholder.

---

Date

---

Signature of Policyholder

**DECLARATION**

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.

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://www.greateasternlife.com/sg/en/pncpolicies.htm> and which I confirm I have read and understood, including without limitation:

- (a) 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
- (b) 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 the relevant insurance benefits, and a copy of this form shall be treated as valid and binding as if it were the original.

\_\_\_\_\_  
Signature of Policyholder

Name: \_\_\_\_\_

NRIC/ Passport No: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policyholder