Great Eastern General Insurance Limited (Reg. No. 1920 00003W)
(A wholly-owned subsidiary of Great Eastern Holdings Limited)
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Great Eastern
A member of the OCBC Group

HEALTH CLAIM FORM

Please state as fully and accurately as possible the information asked for below and to return this form immediately to Great Eastern General Insurance Limited ("Company") with original final bills/receipts. The acceptance of this form is not in itself an admission of liability on the part of the Company.

SECTION A – INSURED'S DETAILS

Name of Insured	NRIC No.	Policy No.
Address	Gender: Male / Female ☐ ☐	Contact No.

SECTION B – CLAIMANT'S DETAILS

Name of Claimant	NRIC No.	Date of Birth
Address		
Email	Gender: Male / Female ☐ ☐	Occupation
	Industry of Business	Relationship to Insured

SECTION C – CLAIM DETAILS

1. PLEASE COMPLETE IF HOSPITALISATION WAS DUE TO ACCIDENT:	
(a) Date and Time of Accident.	(a) Date: _____ (D/M/Y) Time: _____
(b) Nature of Accident (*Describe in details, how & where it happened*).	(b)
(c) Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (*eg. fracture, cut, bruise, etc*).	(c)
2. PLEASE COMPLETE IF HOSPITALISATION WAS DUE TO SICKNESS:	
(a) Nature of Sickness (*describe the symptoms suffered*).	(a)
(b) Date of when symptoms were first noticed.	(b)
(c) Date of first consultation with a medical practitioner for this condition.	(c)
(d) Has the claimant ever seen a doctor for any similar condition in the past?	(d) ☐ No ☐ Yes, Name of Doctor: _____ Address of Doctor/Hospital: _____ _____
3. (a) Name of Hospital	(a)
(b) Period of Hospitalisation	(b) Date Admitted: _____ Date Discharged: _____
4. If Claimant was hospitalised outside Singapore, please give the following information:	
(a) Name of Hospital.	(a)
(b) Purpose of the overseas trip.	(b)
(c) Intended itinerary or destination.	(c)
(d) Intended duration of overseas trip.	(d) From: _____ To: _____
5. Name and Address of the Claimant's usual Doctor(s).	

SETTLEMENT OPTION

PayNow is the default settlement option up to S$200,000 per policy:
In line with the nation's initiatives to go cheque-free by 2025, PayNow is the default settlement option up to S$200,000 for policyholder who has registered with PayNow and has linked his/ her Singapore NRIC to the bank account ("PayNow Account"). You hereby authorise and instruct The Company to deposit the payment that is payable to you into your PayNow Account as well as verify your PayNow Account with the respective Bank ("where necessary").

In the event that the PayNow transaction is unsuccessful, a cheque for the payment will be issued to you (additional 7 to 14 working days would be required for cheque prepared and despatched).

DECLARATION AND AUTHORISATION

I/We hereby declare that the particulars stated above are true and correct in every detail and I/we agree that if I/we have made or in any further declaration in respect of the same claim shall make any false or fraudulent statements or suppress conceal or falsely state any material fact whatsoever the relevant insurance policies shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Without prejudice to the consent given below in respect of my/our personal data, I/we hereby authorise any hospital physician, other person who has attended or examined me/us, to furnish to the Company, or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

PERSONAL DATA

In addition to the declaration and authorisation provided above, I/we 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 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 evaluate, admit, process and/or administer my/our claims.

These purposes are set out in Great Eastern's Privacy Statement, which is accessible at https://www.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I/we confirm I/we have read and understood.

Claimant's signature: _____ Date: _____ Insured's signature: _____ Date: _____
(*See Note Below*)
Note: If (a) The Policyholder is claiming on his own belief or (b) the Claimant concerned is a Child under 18 years of age - only the policyholder's signature is required.

NB. No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the Insured.

SECTION D - ATTENDING DOCTOR'S STATEMENT

1. Name of Patient	2. NRIC No.	3. Date of Birth
4. (a) If Injury: When did Accident occur? (b) If Sickness: When did symptoms first appear?	(a) (b)	
5. (a) State the Nature of Injury or Sickness (*Describe complications - If any*). (b) Final Diagnosis. (c) Nature of Surgery (*if any*).	(a) (b) (c)	
6. (a) When did the Patient first receive medical attention for this condition? (b) By Whom? Name of Doctor. (c) Address	(a) (b) (c)	
7. Has the Patient ever had this or any similar condition?	☐ No ☐ Yes, details: _____	
8. Is the present condition of patient due to: (a) congenital anomaly? (b) nervous or mental disorder? (c) pregnancy/childbirth/infertility? (d) alcohol influence?	(a) ☐ No ☐ Yes, specify: _____ (b) ☐ No ☐ Yes, specify: _____ (c) ☐ No ☐ Yes, specify: _____ (d) ☐ No ☐ Yes, specify: _____	
9. Period of Hospitalisation.	Date Admitted: _____ Date Discharged: _____	
10. Name and Address of Hospital Admitted.		
11. Are you the Patient's usual Doctor?	(a) ☐ No ☐ Yes If no, name and address of usual Doctor: _____ _____	

I hereby certify that I have personally examined and treated the patient for the above *injury/sickness and that the facts as given above present my opinion of his/her condition.

Name of Doctor: _____

Date: _____

_____
Signature & Official Stamp of Doctor

* to delete as applicable