LONG TERM GOLDENCARE CLAIMANT'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

Important Note: (1) The Great Eastern Life Assurance Company Limited hereby referred to as "The Company".
(2) To be completed by the Policyholder.

* Please delete where appropriate

1 POLICY (IES) ISSUED BY THIS COMPANY

☐ Great Eastern Life Policy No(s).:

2 DETAILS OF POLICYHOLDER (Please complete in BLOCK letters)

Name (According to NRIC/ Passport):

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

Occupation:

Home Tel: Office Tel: HP No.:

E-mail Address:

3 DETAILS OF LIFE ASSURED (if different from (2)) (Please complete in BLOCK letters)

Name (According to NRIC/ Passport):

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

Home Tel: Office Tel: HP No.:

E-mail Address:

4 DETAILS OF CURRENT DISABILITY

(a) If the disability suffered is due to illness, please provide:

(i) Date symptoms started: Day | Month | Year

(ii) Describe in detail all the symptoms presented:

Date

Signature of Policyholder

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
The Overseas Assurance Corporation Limited (Reg No. 1920 00011W)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

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(c) If the Life Assured's disability is due to accident:

(i) Date of accident: Day | Month | Year

(ii) Time of accident: _____

(iii) Detailed description of the accident:

_____

_____

(iv) Detailed description of the injuries:

_____

_____

(d) Has the Life Assured suffered from this disability before? YES / NO *

If " YES", give dates and details of the doctors consulted.

_____

_____

(e) State the date when the Life Assured's disability totally prevented him/ her from performing his/ her occupation.

Day | Month | Year

(f) State the names and addresses of all doctors who treated the Life Assured for his/ her present disability.

Name(s)	Address(es)	Date of First Consultation

(g) If as a result of the disability, the Life Assured has been:

(i) Hospitalised, give:

Name(s) of Hospital(s)	Date(s) of Admission	Date(s) of Discharge

(ii) Confined to his/ her home, give the dates of confinement: From: Day | Month | Year To: Day | Month | Year

_____ Date

_____ Signature of Policyholder

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Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
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5 SOURCES OF INCOME

Give particulars of any benefit, salary or remuneration the Life Assured is receiving or he/ she expects to receive because of or during his/her disability from any other insurance company, employer or from any other source. (Attach documentary evidence).

Source	Amount	Date of Commencement of Payment	Date of Termination of Payment
	$_____ per _____		
	$_____ per _____		
	$_____ per _____		

6 DETAILS OF RESIDENCE

Since policy commencement, has the Life Assured had any intention of residing outside Singapore for a period of 6 months or more in near future? YES / NO *

If "YES", state:

(i) Date of leaving Singapore: Day Month Year

(ii) Date of return: Day Month Year

7 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*

8 OTHER INSURANCE

Is the Life Assured claiming from any other insurance company or other sources in respect of this disability? 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)

Date

Signature of Policyholder

Claims Department
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Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
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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: _____