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

FOREIGN WORKER MEDICAL INSURANCE (HGG) CLAIM

Please state as fully and accurately as possible the information asked for below and to return this form immediately to the Company with supporting documents. The acceptance of this form is not in itself an admission of liability on the part of the Company.

CLAIM SUBMISSION PROCEDURES

Please read carefully before you complete the attached Claim Form.

1. The Great Eastern General Insurance Limited ("Company") does not admit liability by the mere issue of this Form.
2. Please complete and answer all questions in full and circle the appropriate boxes provided. Please indicate "N.A.", if the question is not applicable in your case.
3. Please submit the Claim Form and all claim documents (see below) within 30 days from the date of discharge from hospital or date of surgery.
4. Please submit only original final itemised bills (not summarized bills) and receipts. Photocopies of bills/receipts are NOT acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.
5. Please include a copy of work permit or employment pass for claim processing.

CLAIM DISCHARGE

If the Company admits liability and makes payment to the payee indicated on Part I - Statement by Policyholder (Employer), acceptance of our cheque will fully discharge the Company of all liabilities in respect of this claim.

PART I – STATEMENT BY INSURED (EMPLOYER)

NAME OF EMPLOYER (INSURED)		POLICY NO.	UNION MEMBER? YES NO
EMAIL ADDRESS (Acknowledgement of receipt of claim will be provided through email only)			
NAME OF EMPLOYEE (INSURED PERSON)		EMPLOYEE'S COMMENCEMENT DATE OF INSURANCE: (DD/MM/YYYY)	
MALE FEMALE	OCCUPATION:	EMPLOYEE'S DATE OF EMPLOYMENT: (DD/MM/YYYY)	
NRIC/FIN NO.	DATE OF BIRTH: (DD/MM/YYYY)	PLAN TYPE:	

PART II - STATEMENT BY INSURED PERSON (EMPLOYEE)

NAME		DATE OF HOSPITALISATION / SUGERY: (DD/MM/YYYY)	
NRIC / FIN NO.	DATE OF BIRTH: (DD/MM/YYYY)	MALE FEMALE	TOTAL AMOUNT INCURRED:

SICKNESS	
DIAGNOSIS / SYMPTOMS	DATE SICKNESS 1st BEGAN (DD/MM/YYYY)
HAS THIS CONDITION BEEN TREATED PREVIOUSLY? YES NO	DATE 1st TREATED: (DD/MM/YYYY)
NAME OF DOCTOR	ADDRESS OF DOCTOR'S CLINIC
DID THIS DOCTOR REFER YOU ON HIS OWN ACCORD TO THE SPECIALIST WHO IS NOW TREATING YOU? YES NO (If yes, please attach Doctor's referral letter)	

ACCIDENT
DATE & TIME OF ACCIDENT:
DETAILED DESCRIPTION ON HOW THE ACCIDENT HAPPENED AND STATE THE EXTENT OF INJURY:
IS THE ACCIDENT WORK-RELATED? YES NO
ARE YOU MAKING A CLAIM FROM OTHER INSURANCE COMPANIES? YES NO (If yes, please submit a copy of the other insurance company's claim settlement letter/payment voucher)

PART III – SETTLEMENT OPTION

PayNow to my Company Unique Entity Number (UEN) linked bank account. This is the default option for payment that fulfills the criteria stated on below. PayNow is applicable for payment up to S$200,000 and for insured who have their Company Unique Entity Number (UEN) linked with participating banks. Please ensure that you have registered with PayNow and have linked your Company Unique Entity Number (UEN) to your bank account (“PayNow Account”) whereby you are the legal and beneficial owner of the PayNow Account. I hereby authorise and instruct the Company to deposit the payment to me into my PayNow Account as well as consent to the participating banks disclosing any personal data as in reasonably required by the Company to verify my PayNow Account. In the event that the PayNow transaction is unsuccessful for whatever reason, I agree and acknowledge that a cheque for the payment will be issued to me.

If the payment do not meet the criteria stated, or you prefer to receive payment via other means, please indicate your option as follows.

Mail Cheque to me.
Additional 7 to 14 working days would be required for cheque to 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 http://www.greateasternlife.com/sg/en/pncpolicies.htm and which I/we confirm I/we have read and understood.

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Signature of Insured Person / Date

____
Signature of Insured / Date
(Please provide Company Stamp)

PART IV – DOCTOR'S STATEMENT (TO BE COMPLETED BY ATTENDING DOCTOR)

INSURED/EMPLOYER must bear the fee charged, if any, for the completion of this medical report. The Company will not reimburse any part of this fee.

PATIENT'S FULL NAME	NRIC / FIN NO.	DATE OF BIRTH (DD/MM/YYYY)
NAME OF THE HOSPITAL ADMITTED	DATE OF ADMISSION (DD/MM/YYYY)	DATE OF DISCHARGE (DD/MM/YYYY)

Please state the diagnosis of all medical conditions treated and describe of the symptoms of illness or injury.	DATE OF DIAGNOSIS (DD/MM/YYYY)
Please give the date of onset and duration of complaints. If no complaints, please state reasons for seeking medical attention.	DATE OF 1ST CONSULTATION (DD/MM/YYYY)
Please give dates of previous treatment if patient has a history of these complaint(s) before. (DD/MM/YYYY)	
Please give the names and address of the doctor who treated the patient previously or referred the patient to you.	
Please state the patient's diagnosis	1st diagnosed date (DD/MM/YYYY)
If there are more than 1 diagnosis, kindly advise whether if they are related directly or indirectly to each other. Please explain.	YES NO
What is the underlying cause(s)?	Diagnosed Date (DD/MM/YYYY)

Was the treatment provided to the patient for:	
a) Congenital anomaly?	NO YES if YES, please explain: ______________________
b) Self-inflicted injuries or alchoholism or drug addiction?	NO YES if YES, please explain: ______________________
c) Mental or Psychiatric disorder?	NO YES if YES, please explain: ______________________
d) Pregnancy or Childbirth related complications?	NO YES if YES, please explain: ______________________

Type of operation(s) / surgical procedure(s) performed	Date Performed (DD/MM/YYYY)
Please indicate treatment rendered if no surgery was done.	

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Signature of Doctor / Surgeon
Full Name:
Date:

____
Address and Qualification of
Doctor / Surgeon
(please affix Doctor's Stamp)