HOSPITALISATION CLAIM CLAIMANT'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

Important Note:
(1) The Great Eastern Life Assurance Company Limited And/ Or The Overseas Assurance Corporation Limited hereby referred to as "The Company".
(2) The Company does not admit liability by the mere issue of this or any other form.
(3) The Doctor's Statement must be furnished (at the expense of the Policyholder) if the claim amount exceeds S$2,000 or the deductible amount for SupremeHealth / MaxHealth Claim / Premier Health Plan (with deductible).
(4) To be completed by the Policyholder.

* Please delete where appropriate

1 POLICY (IES) ISSUED BY THIS COMPANY

Great Eastern Life Policy No(s).:

Overseas Assurance Corporation 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 *

Residential Status at the point of treatment: Singaporean / Singapore PR / Foreigners*

Occupation:

Home Tel: Office Tel: HP No.:

E-mail Address: ______

Claims Acknowledgement Update via SMS : YES / NO* *(Kindly note that this SMS facility is available for Great Eastern Life policies only).*

3 DIRECT CREDITING OF CLAIMS *(Excludes OAC Claims)*

Name of Bank	Branch of Bank	Bank Account Number	Account Holder's name

Important Notes: -
Direct Crediting will only be applicable for claims (excluding reimbursement to CPF Board) up to S$10,000 to a local bank account. Claim amounts will only be direct credited to the Policyholder's bank account. A cheque will be issued if claim is above S$10,000.

The Company will continue to credit all further claim benefits payable for the same event to the above bank account, unless otherwise notified by the Policyholder.

4 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 *

Residential Status at the point of treatment: Singaporean / Singapore PR / Foreigners*

Home Tel: Office Tel: HP No.:

E-mail Address: ______

______ 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: MedicalClaims-SG@greateasternlife.com Website: greateasternlife.com

CCLM
CCLMCLAHOS

Jan 2015

5 DETAILS OF LIFE ASSURED'S OCCUPATION

Occupation: ____________________

Name of Employer: ____________________

Address of Employer: ____________________ Postal Code: ____________

Description of Duties: ____________________

____

6 CONDITION (IF DUE TO ILLNESS OR INJURY)

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

____

____

(b) When did the Life Assured have the symptoms before he/ she consulted a doctor?

Day		Month		Year			

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

Day		Month		Year			

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

____

____

(e) Describe fully the extent and nature of the illness or injury.

____

____

(f) What is the hospital/ doctor's diagnosis?

____

____

(g) Was surgery performed for this condition? YES / NO*

If "YES", please specify.

Nature of Surgical Operation(s)	Date(s) Performed (D/M/Y)	Surgical Table

____________ ____________

Date Signature of Policyholder

Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
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Jan 2015

7 ACCIDENT (IF APPLICABLE)

(a) Date of Accident: Day | Month | Year ____ (b) Time of Accident: ____

(c) Place of Accident: ____

(d) Detailed description of Accident: ____

____

____

(e) Name(s) and telephone no(s) of witness(es):

Name of Witness	Telephone No.

8 HOSPITALISATION

(a) How was the Life Assured admitted to the hospital? [please tick]

☐ Referral by a General Practitioner/ Specialist/ Other Hospital*
Please provide the name and address of doctor/ hospital: ____

____

☐ A & E department

9 DETAILS OF REGULAR DOCTOR(S)

(a) Name(s) and address(es) of the Life Assured's regular/ company doctor(s):

Name(s)	Address(es)	Date(s) of Consultation	Reason(s) for Consultation

(b) (i) Does the Life Assured have the same medical condition previously or any other medical conditions not stated above?YES / NO*

(ii) If "YES", please state:

Date of Onset: Day | Month | Year ____ Date of Diagnosis: Day | Month | Year ____

Medical condition: ____

Medical treatment received: ____

____ Date

____ Signature of Policyholder

Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
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10 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*

11 OTHER INSURANCE

Is the Life Assured claiming for medical expenses from any other sources (e.g. employer, other medical insurances)? YES / NO*
If "YES", please provide the following information.

Name of Employer, Insurance Company, etc	Date of Issue	Type of Plan	Claim Amount	Claim Notified (YES/ NO)

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. By providing the details of my bank account in Section 3 above, I hereby authorise Great Eastern to credit any claim proceeds of not more than S$10,000 into the aforesaid bank account.

____
Signature of Policyholder

Name: ____________________________

NRIC/ Passport No: ____________________

Date: ____________________________