

CLAIMANT'S STATEMENT

Important Note:

- 1 The Great Eastern Life Assurance Company is hereby referred to as "The Company".
- 2 To be completed by the Policyholder. Submit this together with relevant tests.
- 3 All eligible policies will be processed together.
- 4 *Please delete or circle where appropriate. Date format in **dd/mm/yyyy**.
- 5 Please ensure your contact details with the Company, including mobile no. and email address are updated to receive your correspondences.



Select the type of claim: ☐ Terminal Illness ☐ Juvenile Benefit ☐ Other Benefits (Senior/Special)

1 Details of Policyholder / Life Assured

Full Name: _____

NRIC No. / Passport No. / FIN No.: _____

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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

Details of Life Assured (if different from Policyholder)

Full Name: _____

NRIC No. / Passport No. / FIN No.: _____

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Highest Education Level: _____

2 Occupation Details (Applicable for Terminal Illness Claim)

Note: If the Life Assured is not working before disability, provide a list of daily activities before and after the disability.

Before Disability

After Disability

- (a) Name of Employer: _____
- (b) Date first day of work: _____
- (c) Date last day of work: _____
- (d) Monthly income (S\$): _____
- (e) Position & main duties: _____
- (f) Are you self-employed, or was an independent contractor or sole proprietor before disability? YES / NO*

3 Details of Claim and Medical Consultation History

- (a) Date symptoms first appeared: _____ / _____ / _____
- Describe symptoms in full: _____
- Details of accident, if applicable: _____
- (b) Date first consulted a doctor: _____ / _____ / _____
- Name and Address of Doctor: _____
- Treatment and Advice given: _____
- (c) Date condition first diagnosed: _____ / _____ / _____
- Full and exact diagnosis: _____
- Name and Address of Doctor: _____

(d) Details of other doctors whom the Life Assured consulted for this condition (or similar condition in the past):

| Date of Consultation | Diagnosis | Name & Address of Doctor Consulted |
|----------------------|-----------|------------------------------------|
| | | |
| | | |

(e) Does the Life Assured suffer from any other medical condition or disability? YES / NO*

If "YES", please provide details.

| Date First Diagnosed | Medical Condition/Disability | Name & Address of Doctor Consulted |
|----------------------|------------------------------|------------------------------------|
| | | |
| | | |

Signature of Claimant

Date

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659

For enquiries, call (65) 6248 2888 or visit us at [greateasternlife](http://greateasternlife.com) > Contact Us



CCLM

greateasternlife.com

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4 Other Insurance

Does the Life Assured have any existing insurance policies with other financial institutions?

YES / NO*

If "YES", please provide details of all policies.

| Date of Issue | Name of Insurer | Type of Plan | Sum Assured (S\$) | Claim Notified |
|---------------|-----------------|--------------|-------------------|----------------|
| | | | | |
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5 Settlement Option

PayNow is the (Default Settlement Option)

I confirm that I have registered with PayNow and I have linked my Singapore NRIC/FIN to my bank account ("PayNow Account") whereby I am the Legal and Beneficial Owner of the PayNow Account. I hereby authorise and instruct The 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). This is applicable to SGD denominated policies only.

☐ **Direct Credit option (if you do not have a "PayNow Account")**

By selecting this option, I confirm that I have provided a copy of my recently issued bank statement / passbook / e-statement showing your full name, ID / address, bank name, branch and account number (with transaction and other details blanked out) for verification purposes.

| | |
|------------------------------------|-------------------------|
| Name of Bank Account Holder | Bank Account No. |
| Name of Bank | Name of Branch |

☐ **Telegraphic Fund Transfer (For Claimant residing overseas only)**

Subject to The Company's approval, we will advise on further document(s) required.

Declaration

I hereby declare that to the best of my knowledge and belief, 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/Life Assured's 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 <https://www.greasternlife.com/sg/en/privacy-and-security-policy.html> 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/Life Assured from any persons possessing the same (such as doctors whom I/Life Assured 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/Life Assured (including my/Life Assured's 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.

Full name: _____
NRIC/Passport/FIN No.: _____
Email address: _____

Signature of Policyholder: _____
Date (dd/mm/yy): _____
Occupation: _____

