

## FREE 30-DAY DASH PROTECT – BASIC CLAIM INFORMATION

Basic Claim Information	
Full Name	
Mobile number registered with Singtel Dash Remit	
Date of remittance	

### **Instructions:**

- 1) Complete the above Basic Claim Information
- 2) Complete the accompanying Personal Accident Claim Form
- 3) Email completed form and accompanying supporting documents to [nonmotorclaims-sg@greateasterngeneral.com](mailto:nonmotorclaims-sg@greateasterngeneral.com)

### **Documents to be submitted:**

#### For Death

- A copy of the Death Certificate
- Autopsy Report, Coroner's findings, etc.
- Police Report, if any
- Proof of relationship between the insured person and claimant

#### For Permanent Disablement

- Medical and/or specialist report

#### For Post Hospitalisation Recovery

- A copy of the Final hospital bill
- Hospital discharge summary
- Medical report, if available

## PERSONAL ACCIDENT CLAIM FORM (Free 30-Day Dash Protect)

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 - CLAIM INFORMATION		
Name of Insured:	NRIC No.:	Policy No.:
Address:	Sex: Male / Female	Contact No.:
1. Name of Claimant:	2. Date of Birth:	3. Gender: Male/Female
4. Email:		
5. Present occupation ( <i>if more than one, state all</i> ).		
6. Exact nature of occupational duties and monthly earnings.		
7. Name, Address of business or employer.		
8. Date and Time of Accident.	Date: _____ (D/M/Y) Time: _____	
9. Nature of Accident ( <i>Describe in details, how &amp; where it happened</i> ).		
10. Describe in details the injuries sustained, indicating the part of the body injured and the type of injury ( <i>eg. fracture, cut, bruise, etc.</i> )		
11. Name and Address of doctor(s) who treated you and consultation date(s).		
12. Details of Hospitalisation ( <i>Attach discharge note &amp; hospital bill</i> ): (a) Name of hospital (b) Period of hospitalisation	(a) (b) Date Admitted: _____ Date Discharged: _____	
13. Date last worked prior to disability.		
14. Date returned/expected to return to work.		
15. How long have you been totally or partially disabled from engaging in or attending to your usual business as a result of the injuries?		
16. Name and Address of any witness of the incident.		
17. Name and Address of your usual family doctor.		
18. Are you claiming from any other insurance company or other sources in respect of this injury? If yes, state:		
Name of Insurance Company	Policy No.	Amount of Benefits
		Date Insurance Effected

## SECTION B - MODE OF PAYMENT (PLEASE TICK ONE)

1.  Cheque
2.  PayNow (Link to NRIC)

I/We confirm that I/we have registered with PayNow and I/we have linked my/our Singapore NRIC to my/our bank account ("PayNow Account") whereby I/we am/are the legal and beneficial owner of the PayNow Account. I/We hereby authorize and instruct Great Eastern General Insurance Limited to deposit the payment that is payable to me/us into my/our PayNow Account as well as to verify my/our PayNow Account with the respective Bank (where necessary). In the event that the PayNow transaction is unsuccessful, I/we agree and acknowledge that a cheque for the payment will be issued to me/us.

### **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.

\_\_\_\_\_  
Insured/Claimant's Signature / Date

\_\_\_\_\_  
Verified by Employer (if applicable)

N.B. 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 C - ATTENDING DOCTOR'S STATEMENT		
1. Name of Patient	2. NRIC No.	3. Date of Birth
4. Date on which you first saw the patient.		
5. Is condition due to Injury or Sickness? <input type="checkbox"/> Sickness <input type="checkbox"/> Accident on _____(D/M/Y)		
6. Was the patient referred to you by another doctor? If so, please furnish Name and Address of referral doctor.		
7. (a) Of what symptoms did the patient complain? (a) (b) According to the patient, how long had he/she been experiencing these symptoms? (b)		
8. In your opinion, how long do you feel the symptoms had lasted?		
9. Had the patient previously seen any other doctor or receive treatment on account of these symptoms? If so, please give details.		
10. (a) What is your final diagnosis? (a) (b) Does injury results in fracture of bones? If yes, which part of the body? (b) <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ Simple Fracture <input type="checkbox"/> Compound Fracture <input type="checkbox"/>		
11. Did Injury or Sickness require: (a) Hospitalisation? (a) <input type="checkbox"/> No <input type="checkbox"/> Yes    Date Admitted: _____ Date Discharged: _____ (b) X-rays? (b) <input type="checkbox"/> No <input type="checkbox"/> Yes (c) Special diagnostic procedure? (c) <input type="checkbox"/> No <input type="checkbox"/> Yes (d) Surgery? (d) <input type="checkbox"/> No <input type="checkbox"/> Yes    Type of Surgery: _____ _____		
12. Is patient still under your care for this condition? <input type="checkbox"/> No <input type="checkbox"/> Yes		
13. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him from working?		
14. How long was or will patient be continuously totally disabled (unable to work)?		
15. How long was or will patient be partially disabled?		
16. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.		
<p>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.</p> <p>Name of Doctor: _____</p> <p>Date: _____</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">Signature &amp; Official Stamp of Doctor</p> <p>* to delete as applicable</p>		