FREE 30-DAY INSURANCE FOR PREPAID CUSTOMERS BASIC CLAIM INFORMATION

Basic Claim Information	
Full Name	
Singtel prepaid mobile number	
Date of prepaid card activation or top-up	

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

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

For Job Loss Emergency Funds

- A copy of the final hospital bill
- Hospital discharge summary
- Medical and/or specialist report or memo confirming that the claimant is medically unfit to perform the major duties connected with their employment
- A Letter of Termination from employer showing the reason for termination

PERSONAL ACCIDENT CLAIM FORM
(FREE 30-DAYS INSURANCE FOR PREPAID CUSTOMERS)

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: *(Acknowledgement of receipt of claim will be provided through email only)*		
5. Present occupation (*if more than one, state all*).		
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 (*Describe in details, how & where it happened*).		
10. Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (*eg. fracture, cut* bruise, etc.)		
11. Name and Address of doctor(s) who treated you and consultation date(s).		
12. Details of Hospitalisation (A*ttach discharge note & hospital bill*): (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 - SETTLEMENT OPTION

PayNow is the (Default settlement option)
PayNow is the default settlement option up to S$200,000 for policyholder who has registered with PayNow and has linked his/ her Singapore NRIC/ valid Fin to the bank account ("PayNow Account"). You hereby authorise and instruct The Company to deposit the payment that is payable to you into your PayNow Account as well as verify your PayNow Account with the respective Bank ("where necessary").

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 https://www.greateasternlife.com/sg/en/privacy-and-security-policy.html 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?	☐ Sickness ☐ 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? (b) According to the patient, how long had he/she been experiencing these symptoms?	(a) (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? (b) Does injury results in fracture of bones? If yes, which part of the body?	(a) (b) ☐ No ☐ Yes, _____ Simple Fracture ☐ Compound Fracture ☐	
11. Did Injury or Sickness require: (a) Hospitalisation? (b) X-rays? (c) Special diagnostic procedure? (d) Surgery?	(a) ☐ No ☐ Yes Date Admitted: _____ Date Discharged: _____ (b) ☐ No ☐ Yes (c) ☐ No ☐ Yes (d) ☐ No ☐ Yes Type of Surgery: _____	
12. Is patient still under your care for this condition?	☐ No ☐ 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.		

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.

Name of Doctor: _____

Date: _____

* to delete as applicable

_____
Signature & Official Stamp of Doctor