HOSPITALISATION CLAIM
CLAIMANT'S STATEMENT

Great Eastern
A member of the OCBC Group

Important Note:
(1) The Great Eastern Life Assurance Company 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 Great 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

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: _____

3 SETTTLEMENT OPTION

☑ **PayNow to my Singapore NRIC 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 policyholders who have their Singapore NRIC linked with participating banks. Please ensure that you have registered with PayNow and have linked your Singapore NRIC 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.

☐ **Credit into my personal bank account.**

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

Claim amounts will only be direct credited to the Policyholder's bank account. Please provide a copy of your 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 verfication. Direct crediting will only be applicable for claims (excluding reimbursement to CPF Board) up to S$10,000 to a local bank account. A cheque will be issued if the requirement for direct crediting is not met, or if the amount is above S$10,000.

☐ **Mail Cheque to me.**
Additional 7 to 14 working days would be required for cheque to prepared and despatched.

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.:

Date

Signature of Policyholder

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Health Claim Services Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: MedicalClaims-SG@greateasternlife.com Website: greateasternlife.com

CCLM
CCLMCLAHOS

5 DETAILS OF BIOLOGICAL CHILD OF LIFE ASSURED (Please complete in BLOCK letters)

(Applicable for Congenital Abnormalities of the Life Assured's Biological Child benefit under Supreme Health / Total Health policy only)

Name (According to Birth Certificate):

Birth Certificate No.:

Date of Birth (dd/mm/yyyy):

Gender: M / F *

Important Notes:
1) Please provide the details of the child's congenital condition and his/her hospitalization in the subsequent section of this form
2) Please submit a copy of the child's Birth Certificate

6 DETAILS OF LIFE ASSURED'S OCCUPATION

Occupation: _____

Name of Employer: _____

Address of Employer: _____ Postal Code: _____

Description of Duties: _____

7 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

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Health Claim Services Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: MedicalClaims-SG@greateasternlife.com Website:greateasternlife.com

Dec 2022

8 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.

9 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

10 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

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Health Claim Services Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: MedicalClaims-SG@greateasternlife.com Website: greateasternlife.com

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.

Note: The following information provided shall apply to the organ donor if he/she shall be eligible for reimbursement under his/her own medical insurance in the event that you are claiming for Living Donor Organ Transplant benefit under Supreme Health / Total Health policy.

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 https://www.greateasternlife.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 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: _____