JUNIOR LIVING ASSURANCE/ MAXCARE JUNIOR 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) 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 *

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 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 *

Home Tel: Office Tel: HP No.:

E-mail Address: _____

4 NATURE OF CLAIM AND RELATED DETAILS

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

_____

_____

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

(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) If consultation was for illness, describe fully the extent and nature of the Life Assured's illness.

(f) If consultation was due to an accident, describe fully the nature of the Life Assured's injuries and how it happened.

(g) Has the Life Assured previously suffered from or received treatment for a similar or related illness? YES / NO*
If "YES", please give full details.

(h) Does the Life Assured suffer from any other medical condition? YES / NO*
If "YES", please give details:

Description of Medical Condition	Date(s) Diagnosed (DD/MM/YY)	Name and Address of Attending Doctor(s)

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)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

5 RECORD OF MEDICAL CONSULTATIONS

(a) Provide the details of any doctors who have been consulted in connection with the Life Assured's illness:

Name(s)	Name(s) of Clinic(s)/ Hospital(s) and Address	Date(s) of First Consultation

(b) Provide the name(s) and address(es) of the Life Assured's regular doctor(s).

Name(s)	Address(es)	Date(s) of Consultation (DD/MM/YY)	Reason(s) for Consultation

6 GENERAL

(a) Has any of the Life Assured's blood relatives suffered from a similar or related illness? YES / NO*

If "YES", please state.

Relationship of Relative	Name of Illness	Date Illness First Diagnosed

7 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*

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)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

8 OTHER INSURANCE

Is the Life Assured claiming from any other insurance company or other sources in respect of this illness/ injury? YES / NO*

If "YES", provide the following information.

Name of Insurer	Date of Issue	Sum Assured	Type of Plan	Claim Amount	Claim Notified (YES/ NO)	Claim Paid (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.

_____

Signature of Policyholder

Name: _____

NRIC/ Passport No: _____

Date: _____