Important Note: Please note that, under the policy terms and conditions, the policy may be void if any information provided in this claim form are made knowingly by you that is materially false or misleading.

Great Eastern
A member of the OCBC Group

GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM

CLAIM SUBMISSION PROCEDURES

Please read carefully before you complete the attached Claim Form.

1. The Great Eastern Life Assurance Company Limited (The Company) does **not admit liability** by the mere issue of this Form.
2. Please complete and answer all questions in full and tick in the appropriate boxes provided. Please indicate "N.A.", if the question is not applicable in your case.
3. Please submit the Claim Form and all claim documents (see below) within **30 days** from the date of discharge from hospital or date of surgery.
4. Please submit both the **original final itemised bills** and **summarized bills** including the receipts. Photocopies of bills/receipts are NOT acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.

ON ADMISSION TO HOSPITAL :

1. On admission, the Patient or his/her family member must sign the **Medisave Authorisation** form (if the Patient's expenses can be paid for out of a Medisave Account), and pay a **deposit** (if any) as required by the hospital.

ON DISCHARGE FROM HOSPITAL

2. On discharge, Employer & Patient must complete **Parts I & II** of the **Claim Form** respectively and attach these documents:

   a. The **original hospital final bills**, outpatient bills, outpatient bills/receipts, and follow-up bills for expenses incurred within 90 days of discharge.
   b. **Referral letter** from a General Practitioner for any Pre-hospitalisation / Pre-Surgery Specialist Consultation.
   c. A photocopy of the **Hospital Admission Summary (if any).**
   d. Documents described below**, depending on whether the Patient was admitted into a Government/Restructured Hospital or a Private Hospital.

**** Government / Restructured Hospital :**

   e. **Discharge Summary** form from the hospital. This is provided **free of charge to the Patient. The Patient must bear the fee charged should The Company obtained on behalf of the Patient.**
   f. **Clinical Abstract Application**, duly completed by the Patient (or Parent/Guardian or Next-of-Kin).

Government / Restructured Hospital *refers to one of the following :*

National Healthcare Group Pte Ltd :-	***Singapore Health Services Pte Ltd :-***
National University Hospital	*Singapore General Hospital*
Tan Tock Seng Hospital	*Changi General Hospital*
Alexandra Hospital	*Khoo Teck Puat Hospital (KTPH)*
	KK Women's & Children's Hospital

**** Private Hospital :**

   g. Patient must request the **Attending Doctor/Surgeon** to complete **Medical Certification of Treatment - Part III** of this **Claim Form** and attach it to the other claim submission documents. **The Patient must bear the fee charged** for the completion of this medical report. **The Company will not reimburse any part of this fee.**
   h. **Clinical Abstract Application**, duly completed by the Patient (or Parent/Guardian or Next-of-Kin).

CLAIM DISCHARGE

1. If the Company admits liability and makes payment to the payee indicated on Part I - Statement by Insured Member (Employee), acceptance of our GIRO payment or cheque will fully discharge the Company of all liabilities in respect of this claim.

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Mailing Address: 1 Pickering Street #10-01 Great Eastern Centre Singapore 048659
Tel 6248 2000 Fax 6532 3478 Website: greateasternlife.com

GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM

PART I - STATEMENT BY INSURED MEMBER (EMPLOYEE)

Name of Employer (Policyholder) :

Policy No. : G

Name of Employee (Insured Member) :

Employee's Commencement Date of Insurance : Day Month Year

Occupation :

Sex : M F

Employee's Date of Employment : Day Month Year

NRIC/PP No:

Date of Birth Day Month Year

Plan Type:

Email Address:

Contact No:

*Please indicate to whom benefit payment should be made to:
(Please refer to Claim Discharge instructions)

* Claim settlement advice should be forwarded to:

Cheque Payable to Employer / Employee (please delete whichever is applicable)

GIRO: Employee's Bank Account (Please complete bank account details below)

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

Authorised Signatory & Date	Name of Authorised Signatory:	Company's Stamp:

Important Notes:-

a. Please fill in only the Employee's bank account as the Company will not allow crediting to any other bank account.

b. The Company will not be held liable for any damages, costs, losses or expenses as a result of the claims proceed being credited into the bank account shown above.

c. The Company will continue to credit all future/further claims benefits to the above Bank Account, unless otherwise notified by the Policyholder/Employee.

d. Please note that GIRO payment applies to bank accounts in Singapore only.

PART II-DETAILS OF PATIENT

Name of Patient :

Relationship to Insured Member : Spouse Child

Date of Hospitalisation/ Surgery/Outpatient visit: Day Month Year

NRIC/PP/BC No:

Date of Birth Day Month Year

*Sex: M F

Total Amount Incurred:

SICKNESS

a. Diagnosis/Symptoms :

b. Date sickness first began :

c. Has this condition been treated previously? Yes No

d. Date first treated :

e. Name of Doctor :

f. Address of Doctor :

g. *Did this Doctor refer you on his own accord to the Specialist who is now treating you? Yes No
(If Yes, please attach Doctor's referral letter)

ACCIDENT

a. Date and Time of Accident :

b. Describe how the accident happened and state the extent of the injury :

c. *Is the accident work-related ? Yes No

d. *Are you making a claim from other insurance companies ? Yes No
If Yes, please state the name of the insurance company and the policy number :
(please submit a copy of the other insurance company's claim settlement letter/payment voucher)

Declaration

a. I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

b. I hereby authorise Great Eastern Life to disclose and/or to obtain from any Insurance Company any & all information with respect to this or any related claim.

c. I hereby authorise any hospital, medical practitioner,clinic or any other person who has medically attended to or examined me or my eligible dependent to disclose to Great Eastern Life all medical records or information with respect to any illness or injury, medical history, consultations, prescription or treatment and copies of all hospital records.

d. A photostat copy of this authorisation shall be considered as effective and valid as the original.

By providing the information set out above, I agree and consent to Great Eastern, its related corporations (the "Companies"), as well as their respective representatives and agents ("Representatives") 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 evaluate, admit, process and/or settle my claims. The 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.

Date: _____ Signature of Insured Member: _____

* *please tick in the appropriate boxes.*

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GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM

PART III- MEDICAL CERTIFICATION OF TREATMENT (TO BE FULLY COMPLETED BY ATTENDING DOCTOR/SURGEON)

Singapore Government/ Restructured Hospital - **Please DO NOT arrange for this form to be completed**. If required, Great Eastern Life will apply on the Patient's behalf and bear up to a maximum of S$75/- of the fee charged for it.

Private Hospital or Hospital Outside Singapore - Please arrange with your **Attending Doctor to complete this Form**. **You must bear the fee charged (if any) for completion of this Form.**

1a. **Patient's Full Name :**

1b. NRIC/PP/BC No.

1c. Date of Birth/Age (Day / Month / Year)

2a. Name of Hospital Admitted :

2b. Date Admitted (Day / Month / Year)

2c. Date Discharged (Day / Month / Year)

3a. Please state the diagnosis of all the conditions treated and give a description of the symptoms of illness or injury.

3b. Diagnosis Code (ICD10)

3c. Date of Diagnosis (Day / Month / Year)

4a. Please give the date of onset and duration of complaints. If no complaints, give reasons for seeking medical attention.

4b. Date of First Consultation : (Day / Month / Year)

5a. Please give dates of previous treatment if patient has a history of these complaint(s) before.

5b. Please give the names and address of the doctor who treated the patient previously or referred the patient to you.

6. *Was the treatment provided to the patient for :

a. Congenital anomaly? Yes ☐ No ☐

b. Self-inflicted injuries or alcoholism or drug addiction? Yes ☐ No ☐

c. Mental or Psychiatric disorder? Yes ☐ No ☐

7. Type of operation(s) / surgical procedure(s) performed.

Date Performed (dd/mm/yyyy)	Type of Operation(s) / Surgical Procedures	**Operation Codes ****	**Tables ****

** *For Surgery done in Singapore and based on* ***Tables of Surgical Operations for Medisave Scheme 1 February 1990.***

8. Please indicate treatment rendered if no surgery was done.

9. Please advise period of medical leave given.

10a *Is patient still under your care for this condition? Yes ☐ No ☐

10b If 'No', please state date of discharge from your care. (Day / Month / Year)

Signature of Doctor/Surgeon

Date :

Name, Address and Qualification of Doctor/Surgeon
(to affix Doctor's Stamp)

* *Please tick in the appropriate boxes.*

GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM
CLINICAL ABSTRACT APPLICATION

FOR OFFICIAL USE ONLY
Claim No :
PID No.:

Form completed by the (please tick one box)

☐ Patient (if aged 21 years and above)

☐ Parent or Guardian (if Patient is a minor)

☐ Next of Kin (if Patient is deceased) **

** Relationship to Patient (if Next of Kin) : _____

Group Policy No.		
Name of Patient		
NRIC / PP / BC No.		
Period of Hospitalisation	to	

I hereby authorise any hospital, physician, or other person who has attended to or examined * me / my child / the above Patient, or is authorised to maintain the Patient's medical records, **to disclose to** (or when requested to do so by) The **Great Eastern Life** Assurance Company Limited **any and** all information with respect to any illness or injury, medical history, consultations, prescriptions or treatment of the Patient. A photostat copy of this authorisation shall be considered as effective and valid as the original.

Patient's Admission / E Unit / Outpatient / Clinic * Number was ☐

Signature of ***Patient or Guardian / Parent or Next of Kin**

Signature of **Witness**

Name _____
BLOCK LETTERS

Address _____

Date : _____

Name _____
BLOCK LETTERS

Address _____

Date : _____

**** Delete as necessary***