

SCHOOL STUDENT'S ACCIDENT PROTECTOR 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 accident.
4. Please submit only **original final itemised bills** (not summarized bills) and receipts. Photocopies of bills/receipts are **NOT** acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.
5. Please submit all claim documents through your Life Planner or your School.
6. This Claim Form must be supported with the following documents :-
 - (i) Claimant's Statement :
 - To be fully completed and signed by Parent/Legal Guardian of the Insured Member (the Insured Student) and the Policyholder (School) if claimant is a student, or
 - To be fully completed and signed by the Patient and the Policyholder (School) if claimant is a Teacher or Non-Teaching Staff.
 - (ii) Medical Examiner's Certificate :
 - (iii) Original Final Itemised Bills and Receipts

- Notes:**
1. The Company reserves the right to call for any original documents.
 2. Insured Member must request the **Attending Doctor/Surgeon** to complete the **Medical Examiner's Certificate** of this **Claim Form** and attach it to the other claim submission documents, **if the claim amount exceeds S\$500.00. The Insured Member must bear the fee charged** for the completion of this medical report. **The Company will not reimburse any part of this fee.**

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

SCHOOL STUDENTS' ACCIDENT PROTECTOR (SPA) CLAIM FORM

PART I - STATEMENT BY POLICYHOLDER (SCHOOL)

Name of School (Policyholder):

 Policy No. :

Name of Student / Teacher / Non-Teaching Staff (Life Insured):

NRIC/PP No:

 Date of Birth:

Day	Month	Year

 Sex : Male Female

*Please state to whom benefit payment should be made to: School (Policyholder) Parent/Legal Guardian Principal / Teacher / Non-Teaching Staff
 *Claim payment should be forwarded to: Life Planner School Directly

Name of Principal / Teacher / Non-Teaching Staff : _____ Attention of : _____

Signature & Date of Principal/Teacher-in-charge:	Name of Principal/Teacher-in-charge:	School (Policyholder)'s Stamp:
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PART II - STATEMENT BY LIFE INSURED (STUDENT / TEACHER / NON-TEACHING STAFF)

Name of Patient:

 NRIC/PP/BC No:

Name of Parent / Legal Guardian (if claimant is a student):

 Sex of Parent / Legal Guardian Male Female

NRIC/PP No of Parent / Legal Guardian (as above)

 Date of Birth of Parents / Legal Guardian

Address (Residence), Including Postal Code:

 Nationality (please tick) Singaporean Others, Please specify _____

Contact Number:

 Relationship to Life insured (please circle): Parent / Legal Guardian

PART III - DESCRIPTION OF ACCIDENT

Place of Accident:

 Date of Accident:

Day	Month	Year

Brief description of Accident: _____

Nature and extent of Injuries sustained: _____

Name(s) / NIRC No(s) of Witness(es): (i) _____ (ii) _____

PART IV - OTHER INSURANCE(S)

Are you entitled to and have obtained compensation for medical expenses incurred for the treatment of the injury(ies) sustained described above from any other source [eg. Parents' employers, other insurances (including Medishield)]?

Yes No

If "YES", please give the following details.

Name of Employer, Insurance Company, etc	Address	Telephone Number

PART V - DECLARATION BY LIFE INSURED

- I DECLARE that the Life Insured received the above injuries solely and directly by violent, accident and visible means.
- I WARRANT that the statements and facts are true and that I have not withheld from the Company any medical information in connection with this claim.

By providing the information set out above, I agree and consent to Great Eastern, its related corporations (collectively, 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. These purposes are set out in Great Eastern's Privacy Statement, which is accessible at <https://www.greasternlife.com/sg/en/privacy-and-security-policy.html> and which I confirm I have read and understood.

Date:

Day	Month	Year

Signature of Parent / Legal Guardian / Teacher / Non - Teaching Staff*

Name of Parent / Legal Guardian / Teacher / Non - Teaching Staff*

***To be completed by Parent or Legal Guardian of student if claimant is a student, or by claimant if claimant is a teacher or non-teaching staff.**

