A Member of the OCBC Group

GROUP TOTAL & PERMANENT DISABILITY 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. This Claim Form must be supported with the following documents :-

   (i) Insured Member's Statement.

   (ii) Clinical Abstract Application Form.

   (iii) Doctor's Statement (refer to note 2 below).

   (iv) Copy of Birth Certificate / Identity Card / Passport of the Insured Member (certified to be a true copy by an authorised senior officer of the Policyholder).

   (v) Copy of Insured Member's latest payslip prior to the commencement of disability (certified to be a true copy by an authorised senior officer of the Policyholder).

   (vi) Copy of Tax Statement - IR8A form (certified to be a true copy by an authorised senior officer of the Policyholder).

   (vii) Any police statement/newspaper report relating to Insured Member's disability if it is due to an accident.

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 **Doctor's Statement** of this **Claim Form** and attach it to the other claim submission documents. **The cost for completion of this Doctor's Statement will have to be borne by the Insured Member / Policyholder.**

3 Authorised Officer of the Policyholder must be stated and declared in MAS 314 Form.

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.

Great Eastern
A Member of the OCBC Group

GROUP TOTAL & PERMANENT DISABILITY CLAIM
INSURED MEMBER'S STATEMENT

Important Note :
(1) The Great Eastern Life Assurance Company Limited is hereby referred to as "the Company".
(2) The Company does not admit liability by the mere issue of this or any other form.
(3) This form must be completed by the Policyholder and signed by an authorised representative.

1. STATEMENT BY POLICYHOLDER (EMPLOYER)

Name of Employer :

Policy No G

Please pay benefits to ___ Employer Employee

Name of Employee :

NRIC/ Passport No :

Date of Birth Day Month Year

Sex ___ Male ___ Female

Occupation

Sum Assured :

Employment Date Day Month Year

Date Last Actively At Work Day Month Year

Average Salary For the Last 12 Months

Date Salary Was Last Adjusted Day Month Year

2. DECLARATION BY POLICYHOLDER (EMPLOYER)

We, the Policyholder, declare that the information given in this statement is true and complete and have not withheld any material fact to the best of our knowledge and belief. We agree that the furnishing of this form, or any other supplemental forms, by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the Insured Member in question nor a waiver of any of its rights or defences.

We hereby confirm and represent to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") that each insured member of the policy ("Insured Members"), under which we are submitting our claims, has agreed and consented to the disclosure of their personal data to the Companies and their Representatives, and further, that for the Companies and their Representatives' collection, use and/or disclosure of the personal data of the Insured Members, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonable required by the Companies to evaluate, admit, process and/or settle our claims. In respect of the Insured Members who are subsequently enrolled into the policy, under which we are submitting our claims, we further undertake that we shall ensure and procure that each of such Insured Members has provided such agreement and consent in relation to his/her personal data for such purposes. 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.

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

3. STATEMENT BY INSURED MEMBER (EMPLOYEE)

Name of Insured Member :

NRIC/ Passport No :

Date of Birth Day Month Year

Sex ___ Male ___ Female

4. DETAILS OF CURRENT DISABILITY

(a) Date of Disability Day Month Year

(b) Describe fully the symptoms for which the Insured Member consulted a doctor.

(c) How long did the Insured Member have the symptoms before he/she consulted a doctor?

(d) Date when the Insured Member First consulted a doctor.

Day		Month		Year			

(e) If the Insured Member's disability is due to sickness, give a full description of his/her illness.

(f) Has the Insured Member suffered from this disability before? Yes No

If "YES", give dates and details of doctors consulted.

Day		Month		Year			

(g)) If the Insured Member's disability resulted from accident:

(i) Describe how the accident occurred and injuries sustained.

(ii) State the date of accident:

Day		Month		Year			

(h) State the date when the Insured Member's disability totally prevented him/her from performing his/her occupation:

Day		Month		Year			

5. DETAILS OF DOCTOR(S) CONSULTED FOR PRESENT DISABILITY

(a) State the names and addresses of all doctors who treated the Insured Member for his/her present disability.

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

(b) If as a result of the Insured Member's disability, he/she has been:

(i) Hospitalised, please give:

Name(s) of Hospital(s)	Date(s) of Admission	Date(s) of Discharge

(ii) Confined to his/her home, please give the dates of confinement:

From:

Day		Month		Year			

To:

Day		Month		Year			

6. OTHER INSURANCES

Is the Insured Member claiming from any other insurance company or other sources in respect of his/her illness or 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	Claim Notified NO
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	☐

12. DECLARATION BY INSURED MEMBER (EMPLOYEE)

I declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted. I agree to the Company seeking information in connection with this claim from any source and I authorise the giving of such information. A photocopy of this authorisation is as valid as the original.
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.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I confirm I have read and understood."

Date:	Day		Month		Year			

Signature of Insured Member

Name of Insured Member

Great Eastern
A Member of the OCBC Group

GROUP TOTAL AND PERMANENT DISABILITY CLAIM
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***

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

A Member of the OCBC Group

GROUP TOTAL AND PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT

Important Note: The Insured Member, named below, is insured with the Great Eastern Life Assurance Co. Ltd against the happening of certain contingent events associated with his/her health. A claim has been submitted and to enable us to access the claim, we will be obliged if you would complete this Doctor's Statement. The fees for the completion of this form shall be paid by the Insured Member.

Name of Insured Member: :

NRIC / Passport No. :

1. CONSULTATION FOR PRESENT ILLNESS / INJURY

(a) Date of first consultation with you / your hospital: Day Month Year

(b) Please state the symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (Day/Month/Year)

(c) What is the source of this information? Patient Referring Doctor Others

If "Others", please specify : _____

(d) Please provide full and exact diagnosis of the Insured Member's condition.

_____

_____

(e) Date when illness/condition was FIRST diagnosed : Day Month Year

(f) Diagnosis was first made by (name of doctor) : _____

(g) Date when Insured Member first became aware of the illness/condition : Day Month Year

(h) Is the condition a result of an accident? Yes No

If "YES", describe in detail how the accident happened.

_____

_____

_____

(i) Was the Insured Member under the influence of alcohol at the time of accident? Yes ☐ No ☐

If "YES", what was the blood alcohol content? _____

(j) Is the disability due to pregnancy, self-inflicted or caused / aggravated by the taking of alcohol or unprescribed drugs? Yes ☐ No ☐

If "YES", please state the cause.

_____

_____

(k) Current occupation before disability: _____

(l) Nature of duties of current occupation.

_____

(m) How did the Insured Member's disability prevent him/her from performing the above listed duties of his/her occupation?

_____

_____

(n) Type of treatment/s including any operations performed and his/response to the treatment/s.

_____

_____

2. Insured Member's Condition

(a) Please describe fully the nature and severity of the Insured Member's disabilities.

_____

_____

(b) Is his / her disability progressive, stationary or improving?

Progressive ☐ Stationery ☐ Improving ☐

(c) Is full recovery expected? Yes ☐ No ☐

If "YES", please state apprpximate date: Day | Month | Year

If "NO", please state the extent of recovery and approximate date. Day | Month | Year

(d) Is the Insured Member able to perform all Activities of Daily Living (ADL) without assistance? Yes ☐ No ☐

If "NO", please state which one(s) of the ADLs he / she is unable to perform independently.
The 6 ADLs include feeding, mobility, continence, bathing, dressing and toileting.

_____

_____

(e) Is the Insured Member confined to a home, hospital or other Institution that provides constant care and medical attention? Yes ☐ No ☐

If "YES", since what date? Day | Month | Year

(f) Does the Insured Member have full power of all limbs? Yes ☐ No ☐

If "NO", please specify which limb(s) do(es) not have full power and the current power of limbs.

_____

_____

(g) Please give full details with respect to the Insured Member's mental abilities and cognition.

(h) Is the Insured Member able to perform all the normal duties of his/her occupation? Yes | No

If "YES", when is he / she expected to return to his usual occupation?

Day		Month		Year			

(i) If he / she is unable to return to his / her usual occupation, is he / she able to engage in any other occupation?

Yes | No

If "YES",

(i) What types of occupation can he / she engage in?

(ii) When can he / she expect to engage in these occupations?

Day		Month		Year			

3. MEDICAL HISTORY

(a) Did the Insured Member consult other doctors for this illness or it's symptoms BEFORE he/she consulted you?

Yes | No

If "YES", please give name(s) and address(es) of the doctor(s) whom he / she consulted.

Name of Doctor	Name of Clinic / Hospital and Address

(b) Is theInsured Member suffering or has suffered from any other significant illnesses? Yes | No

Illness	Date of First Diagnosis (D/M/Y)	Name and Address of Attending Doctor

(c) Are you the Insured Member's regular doctor? Yes | No

If "YES", since what date?

Day		Month		Year			

If "NO", please state the name and address of the Insured Member's regular doctor.

(d) Is the disability total and permanent and result in the "complete inability of the Insured Member to engage in any gainful occupation, profession or employment for compensation, profit or gain for the remainder of his ifetime as a result of accidental bodily injury, sickness or disease; provided however that such disability shall have lasted for not less than six months duration."

Yes	No

If "YES" , when did such disability commence?

Day		Month		Year			

Please provide us with any other additional information that will enable the Insurer to assess this claim. Please enclose copies of laboratory test results.

Signature of Doctor/Surgeon

Date :

Day		Month		Year			

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