DEPENDANTS' PROTECTION SCHEME (DPS)
PERMANENT DISABILITY 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 hereby referred to as "The Company".
(2) To be completed by the Policyholder.
(3) Under Section 3(4) of the CPF (DPS Insurance Scheme) Regulation, the maximum sum for which a member is insured in respect of any incapacity or death which occurred or deemed to have occurred before the implementation date (i.e. before 17 September 2005) shall be $44,000.

* Please delete where appropriate

1 POLICY (IES) ISSUED BY THIS COMPANY

Great Eastern Life 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 DETAILS OF LIFE ASSURED'S OCCUPATION

	Before Disability	After Disability
(a) Occupation:		
(b) Name of employer:		
(c) Average monthly income for 1 year:		
(d) List exact duties performed at work (see Note):		

Note: If the Life Assured is not working, provide a list of daily activities before and after the disability.

Date

Signature of Policyholder

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: claims-sg@greateasternlife.com Website: greateasternlife.com

Jul 2014

CCLM
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5 DETAILS OF DISABILITY

(a) If the disability suffered is due to illness, please provide:

(i) Date symptoms started: Day | Month | Year

(ii) Describe in detail all symptoms presented. _____

_____

(b) If the disability suffered is due to accident, please provide:

(i) Date of accident: Day | Month | Year (ii) Time of accident: _____

(iii) Place of Accident: _____

(iv) Detailed description of the Accident:

_____

_____

(v) Detailed description of the injuries:

_____

_____

(vi) Was the accident reported to the police? YES / NO *

If YES, please provide the name of police division and police officer-in-charge's name.

_____

(Please enclose a copy of the police report.)

(c) Date the Life Assured last worked: Day | Month | Year

(d) Is the Life Assured currently confined to: Bed/ House/ Neither*

(e) Date the Life Assured returned to work: Day | Month | Year

or

Date the Life Assured is expected to return to work: Day | Month | Year

_____ _____

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)
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6 DETAILS OF PHYSICIAN(S) CONSULTED OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY

Name(s)	Address(es)	Date(s) of Consultation / Hospitalisation

7 DETAILS OF REGULAR PHYSICIAN(S)

Details of the Life Assured's regular physician or any other physician(s) consulted for other disorders in the past three years.

Name(s)	Address(es)	Reason for Consultation

8 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*

9 OTHER INSURANCE

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

If "YES", provide the following information.

Name of Employer/ Insurer	Date of Issue	Type of Plan	Claim Amount	Claim Notified (YES/ NO)	Claim Paid (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: claims-sg@greateasternlife.com Website: greateasternlife.com

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. This includes without limitation disclosure to the board of Central Provident Fund ("Board") for purposes of (i) making of a claim under the Dependants' Protection Insurance Scheme or any other insurance scheme referred to in the Central Provident Fund Act (Chapter 36) of Singapore which I may be insured under; and (iii) the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act (Chapter 36) of Singapore.

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. I am aware that the claim amount (if payable) is based on the amount of benefits under the relevant policy as at the date of permanent incapacity.

_____

Signature of Policyholder

Name: _____

NRIC/ Passport No: _____

Date: _____