

INTEGRATED SHIELD CLAIMS RECOVERY AUTHORISATION FORM

To: Health Claim Services Department
The Great Eastern Life Assurance Company Limited (“**Great Eastern**”)
1 Pickering Street #01-01
Great Eastern Centre
Singapore 048659

Name of Life Assured : _____
Policy Number : _____
Hospitalisation Period (the “Hospitalisation”) : _____ to _____

In accordance with the terms of my Integrated Shield Plan, I/we would like to inform you that the Life Assured’s Hospitalisation is also covered under insurance provided by another insurer and/or company. The details of this other insurance are as follows:-

The Other Insurer/Company : _____
(the “**Other Insurer & Company**”)
Policy Number : _____

To enable Great Eastern to seek reimbursement from the Other Insurer/Company of all and any claims Great Eastern has paid out in respect of the Hospitalisation (“**Reimbursement**”), I/we authorise and agree to the following:-

1. Great Eastern can collect, use or disclose, as they reasonably consider appropriate, any information or documents they have to allow them to seek Reimbursement, such as :
 - (a) Great Eastern’s claim settlement letters issued to me; and
 - (b) Medical invoices issued by the Life Assured’s medical provider.
2. The Other Insurer/Company (including its Human Resource personnel, where appropriate) can liaise with Great Eastern directly regarding the procedures and/or documentation required for the Reimbursement. I understand that I/we will still be required to sign-off on the relevant claim forms.

By filling in and sending this Authorisation Form to Great Eastern, I/we agree and consent to Great Eastern, its related corporations (collectively, the “**Companies**”), as well as their respective representatives, agents, the Companies’ authorised service providers and relevant third parties, and the Other Insurer/Company, collecting, using and/or disclosing my/our personal data for purposes reasonably required by Great Eastern to seek Reimbursement.

A photocopy of this authorization is as valid as the original.

Signature of Policyholder*

Signature of Life Assured
(If different from Policyholder)

Name of Policyholder*

Name of Life Assured

Date: _____

Date: _____

Contact Number: _____

Contact Number: _____

(*Policyholder can also be trustee/assignee.)