

PRE-AUTHORISATION REQUEST FORM

Important Notes: (1) The Great Eastern Life Assurance Company Limited hereby referred to as "The Company".

(2) To be completed by GREAT SupremeHealth policyholders only.

(3) Please state as fully and accurately as possible the information asked for below and email the completed form to pre-authorisation@healthconnect.com.sg or fax to 69863069. This form must be submitted at least 3 working days prior to the date of admission for our review.

(4) For any pre-authorisation request, please contact our Health Connect hotline at 6563 2233 for assistance.

(5) The acceptance of this form is not in itself an admission of liability on the part of the Company.



Life Assured Details

1. Name: Same as NRIC / Passport

2. NRIC No. :

3. Policy No. : (if cannot recall, leave blank)

4. Nationality:

5. Date of Birth:

6. Mobile No. :

7. Home Telephone No. :

8. Email Address:

Life Assured Medical Condition

9a. Description of symptoms:

9b. Duration of symptoms:

10a. Date of first onset/awareness of symptoms:

10b. When did you first seek medical attention for the symptoms?

11. Did you have similar symptoms in the past?

Yes No

If yes, please provide the following details:

12a. Diagnosed Medical Condition (If known):

12b. Date of Diagnosis:

13a. Name of diagnosing doctor:

13b. Name of clinic/hospital:

14. Is the current admission (including underlying cause, diagnosis & treatment) related to any of the following:

a. Routine Check-up

Yes No

b. Accident Related

Yes No

c. Infertility / Pregnancy

Yes No

d. Self-Inflicted Injuries

Yes No

e. Alcohol / Drug Abuse

Yes No

f. Clinical Trial / Study / Experimental

Yes No

If yes, please provide the following details:

Additional Information

15. Is this your first claim on the diagnosed medical condition?

Yes No

If no, please state the previous claim date:

16. Do you have a referral letter from your doctor? (if Yes, please attach a copy of the referral letter to us)

Yes No



17. Do you have a regular clinic / family doctor? Yes No

If yes, please provide the following details:

17a. Name of clinic / family doctor:

17b. Address of clinic:

18. Any other medical condition/s? Yes No

If yes, please provide date of first diagnosed and details:

Admission / Surgery Details

19a. Clinic / Hospital Name:

19b. Admission Date:

20a. Planned Procedure / Treatment:

20b. Name of Treating Specialist:

21. Are you covered under another insurance policy? Yes No

If yes, please provide the following details:

21a. Insurer:

21b. Type of Policy:

21c. Policy Number:

22. Ward / Room Type:

Re-Structured / Government

Private

1 Bed 2 Bed 4 Bed 5-6 Bed

1 Bed 2 Bed 4 Bed 5-6 Bed

8-10 Bed Day Surgery (Subsidised/ Non-Subsidised)

Day Surgery

Day(s)

24a. Estimated Hospital Costs:

24b. Estimated Doctor Costs:

Declaration

"By signing below, I warrant that the information given in this form is true, correct and complete. I agree that this form and these declarations shall be the basis of the Company to evaluate my Pre-authorisation request and I accept the term and conditions of the Health Connect service. In the event the Company becomes aware there is a material fact which is not disclosed in this form, the Certificate of Pre-authorisation issued may not be valid."

Signature of Life Assured

Signature of Parent/Guardian
(if Life Assured is under 21 years of age)

Date

Life Assured / Guardian Consent

I, _____ (Life Assured / Guardian name) _____ (NRIC/PP No.), hereby give my consent and authorise the doctor(s), clinic(s), hospital(s) or any person who has attended to or examined me/ my child or is authorised to maintain my/my child's medical record to furnish and release my/ my child's medical report to the 'Great Eastern Life Assurance' (Insurer), its appointed administrator, and its staff and associates with respect to any of my illnesses or injuries, medical history, consultations, prescriptions or treatment.

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/ my child's 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/ my child's 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.

I also agree to the Insurer or Company seeking information from any source and I authorise the giving of such information. A photocopy of this authorisation is as valid as the original. In addition, I hereby agree that this consent shall remain valid notwithstanding my death.

Signature of Life Assured

Signature of Parent/Guardian
(if Life Assured is under 21 years of age)

Date