PRE-AUTHORISATION REQUEST FORM

Great Eastern
A member of the OCBC Group

To be used for Supreme Health policyholders only.
Please complete ALL details and email a copy to pre-authorisation@healthconnect.com.sg or fax to 6896 3069. For any pre-authorisation requests, please contact us at hotline 6563 2233.
This form must be submitted at least 3 days prior to the date of admission for review.

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: D D / M M / Y Y Y Y

6. Mobile No. :

7. Home Telephone No. :

8. Email Address:

Life Assured Medical Condition

9a. Description of symptoms:

9b. Duration of symptoms: Day(s)

10a. Date of first onset/awareness of symptoms: D D / M M / Y Y Y Y

10b. When did you first seek medical attention for the symptoms? D D / M M / Y Y Y Y

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: D D / M M / Y Y Y Y

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

Great Eastern Holdings Limited (Reg. No. 1999 03008M)
The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Mailing Address: 1 Pickering Street #10-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Website: www.greateasternlife.com

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: D D / M M / Y Y Y Y

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

◯ 1 Bed ◯ 2 Bed ◯ 4 Bed ◯ 5-6 Bed
◯ 8-10 Bed ◯ Day Surgery (Subsidised/ Non-Subsidised)

◯ Private

◯ 1 Bed ◯ 2 Bed ◯ 4 Bed ◯ 5-6 Bed
◯ 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 http://www.greateasternlife.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 not withstanding my death.

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