

**DISABILITY INCOME / WAIVER OF PREMIUMS (DISABILITY) CLAIM
CLAIMANT'S STATEMENT**

Important Note: (1) The Great Eastern Life Assurance Company Limited referred to as "The Company".
(2) To be completed by the claimant.

* 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 *

Occupation:

Home Tel: Office Tel: HP No.:

E-mail Address: _____

Date

Signature of Policyholder



4 DETAILS OF EMPLOYMENT (PRE-DISABILITY)

Was the Life Assured gainfully employed at the time of his/ her disability?

YES / NO *

(a) If "YES",

(i) State occupation and describe the Life Assured's duties.

(ii) Name and address of employer.

(b) If "NO", state when the Life Assured ceased being gainfully employed:

| Day | Month | Year |
|-----|-------|------|
| | | |

5 DETAILS OF RESIDENCE

Since your policy commencement, has the Life Assured resided or traveled abroad for a continuous period of 12 months or more?

If "YES", state:

(a) Date of leaving Singapore:

| Day | Month | Year |
|-----|-------|------|
| | | |

(b) Date of return:

| Day | Month | Year |
|-----|-------|------|
| | | |

6 DETAILS OF INCOME

(a) State the Life Assured's average monthly earned income in the 12 months before date of Disability.

(Attach documentary evidence, for e.g. letter from employer, Income Tax Returns, etc)

Amount : _____

(b) How much of this earned income had been lost as a result of his/her disability?

Amount : _____

7 DETAILS OF CURRENT DISABILITY

(a) Date of Disability:

| Day | Month | Year |
|-----|-------|------|
| | | |

(b) If the Life Assured's disability is due to sickness, give a full description of his/ her illness.

(c) Has the Life Assured suffered from this disability before?

YES / NO *

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

Date

Signature of Policyholder

(d) If the Life Assured's disability resulted from accident:

(i) State date of accident:

| Day | Month | Year |
|-----|-------|------|
| | | |

(ii) Time of accident: _____

(iii) Detailed description of the accident:

(iv) Detailed description of the injuries:

(e) State the date when the Life Assured's disability totally prevented him /her from performing his/ her occupation:

| Day | Month | Year |
|-----|-------|------|
| | | |

8 DETAILS OF DOCTOR(S) CONSULTED FOR PRESENT DISABILITY

(a) State the names addresses of all doctors who treated the Life Assured for his/ her present disability.

| Name(s) | Address(es) | Date of First Visit (DD/MM/YY) |
|---------|-------------|--------------------------------|
| | | |
| | | |
| | | |

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

(i) Hospitalised, give:

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

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

| Day | Month | Year |
|-----|-------|------|
| | | |

To:

| Day | Month | Year |
|-----|-------|------|
| | | |

9 DETAILS OF EMPLOYMENT (POST- DISABILITY)

If as a result of the Life Assured's disability, he/ she has not been able to follow his/ her regular occupation full-time, but he/ she is now working part-time or in another occupation,

(a) State the Life Assured's occupation.

Date

Signature of Policyholder

(b) Describe the Life Assured's duties.

(c) State the date the Life Assured started working:

| Day | Month | Year |
|-----|-------|------|
| | | |

10 OTHER SOURCES OF INCOME

Give particulars of any benefit, salary or remuneration the Life Assured is receiving or the Life Assured expects to receive because of or during his/ her disability from any other insurance company, employer or from any other source.
(Attach documentary evidence)

| Source | Amount | Date of Commencement of Payment | Date of Termination of Payment |
|--------|--------------------|---------------------------------|--------------------------------|
| | \$per | | |
| | \$per | | |
| | \$ per | | |

11 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*

12 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 Insurer | Date of Issue | Sum Assured | Type of Plan | Claim Amount | Claim Notified (YES/ NO) | Claim Paid (YES/ NO) |
|-----------------|---------------|-------------|--------------|--------------|--------------------------|----------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

_____ Date

_____ Signature of Policyholder

13 MODE OF CLAIMS PAYMENT (Please Tick) **Please credit my proceeds into my Personal Bank Account in Singapore.**

| Name of Bank | Branch of Bank | Bank Account Number | Account Holder's name |
|--------------|----------------|---------------------|-----------------------|
| | | | |

Important Notes: Claims amount will only be direct credited to the Policyholder's bank account. A copy of bank book or bank statement showing the account holder's name and bank account number has to be submitted for verification purpose. Direct Crediting will only be applicable for claims (excluding reimbursement to CPF Board) up to S\$10,000 to a local bank account. Direct crediting request is on a per claim submission basis, and no standing instruction will be accepted. A cheque will be issued if the requirement for direct crediting is not met or if the amount is above S\$10,000.

 Please credit my proceeds via PayNow.

I confirm that I have registered with PayNow and I have linked my Singapore NRIC to my bank account ("PayNow Account") whereby I am the legal and beneficial owner of the PayNow Account. I hereby authorise and instruct The Great Eastern Life Assurance Company Limited ("Company") to deposit the payment that is payable to me into my PayNow Account as well as to verify my PayNow Account with the respective Bank (where necessary). In the event that the PayNow transaction is unsuccessful, I agree and acknowledge that a cheque for the payment will be issued to me, the Policyholder.

Note: PayNow will only be applicable for claims up to S\$200,000 and payable to Policyholder's local bank account.

 Quick Cheque Deposit.

I wish to request for Quick Cheque Deposit and enclosed a copy of my (Policyholder) bank statement or bank book for verification. I hereby authorise and instruct The Great Eastern Life Assurance Company Limited ("Company") to deposit the cheque to the quick cheque deposit slot of the designated bank stated in my bank statement or bank book.

 Cheque Payment.

I wish to request for Cheque payment. I agree and acknowledge that a cheque for the payment will be issued to me, the Policyholder.

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.greatasteallife.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.

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.

Signature of Policyholder

Name: _____

NRIC/ Passport No: _____

Date: _____