Great Eastern
Life is Great
A member of the OCBC Group

ElderShield **CLAIM FORM**

Dear Policyholder,

We are sorry to learn of your disability.

In order for us to process your claim, please:

1. Complete the attached Claim Form as best as you can. If you are unable to do so, please have it completed by your immediate family member or caregiver.

2. Call the clinic to make an appointment for the severe disability assessment. Please refer to the attached list of appointed assessors. The fee for the assessment is to be paid by you.

3. Bring along the following for the appointment:
   - Completed Claim Form
   - Hospital medical records and discharge summary that you may have
   - Medicine (if possible)

Once we have received all the required documents/information, we will process your claim and inform you of the outcome as soon as possible.

If you need help, please contact our staff at 1800-248 2888 or email to us at LifePAClaims-SG@greateasternlife.com.

乐龄健保 **索赔表格**

敬爱的保单用户，

我们十分同情您的处境，也希望尽快地给予保单赔偿。

为了尽快地处理您的索赔申请，请您：

1. 填妥后面附的索赔表格。如果自己无法填写，可请亲属或看护人代为填写。

2. 从后面所附的合格评估员名单中选出一名评估员，并预约评估时间，请他评估您的残疾情况。不过，评估费自理。

3. 在评估当日携带下列文件赴约：
   - 填妥的索赔表格
   - 完整的病历和出院单(如有)
   - 正在服用的药物(如有)

一旦收到全部所需资料，我们会尽快处理您的索赔，并及时通知您索赔的结果。

若您需要协助，请联络大东方人寿保险 **1800-2482888** 或电邮于 LifePAClaims-SG@greateasternlife.com.

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: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com/eldershield

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ElderShield **BORANG TUNTUTAN**

Pemegang Polisi,

Kami bersimpati di atas keadaan kesihatan anda.

Untuk memproses tuntutan anda itu, sila:

1. Isikan borang tuntutan anda. Jika anda tidak berupaya mengisi borang tersebut, keluarga anda boleh membantu mengisikan borang itu.

2. Hubungi klinik untuk membuat temu janji bersama pegawai penilaian untuk menilai kesihatan anda. Sila rujuk pada senarai nama-nama pegawai penilaian yang telah dilantik. Anda dikehendaki membayar yuran bagi penilaian anda.

3. Bawa bersama dokumen-dokumen berikut sewaktu penilaian itu:
   - Borang Tuntutan anda yang telah dilengkapi
   - Rekod kesihatan anda dari hospital dan juga surat pengesahan pesakit (Inpatient discharge summary)
   - Ubat-ubat anda (jika ada)

Kami akan memproses tuntutan anda setelah menerima segala dokumen yang diperlukan dan akan menghubungi anda secepat mengkin.

Jika anda memerlukan bantuan, sila hubungi kami di 1800-248 2888 atau emel kami di LifePAClaims-SG@greateasternlife.com.

எல்டர்ஷீல்டு கோரிக்கை படிவம்

அன்புடையீர்

தங்களுக்கு ஏற்பட்டுள்ள இயலாமை நிலை அறிந்து வருந்துகிறோம்.

மேற்கொண்டு நாங்கள் செயலாற்ற பின் வருவனவற்றை செய்யுங்கள்.

1. இணைக்கப்பட்டுள்ள கோரிக்கை படிவத்தை தங்களால் இயன்ற வரை பூர்த்தி செய்யுங்கள். தங்களால் இயலவில்லை என்றால் நெருங்கிய குடும்ப உறுப்பினரோ அல்லது தங்களைத் தற்போது கவனித்துக்கொள்பவரோ பூர்த்தி செய்யலாம்.

2. மருத்துவ பரிசோதனை செய்துகொள்ள நாள் குறிக்க மருந்தகத்தை அழையுங்கள். இணைக்கப்பட்டுள்ள நியமன ஆய்வாளர் பட்டியலைக் காண்க. மருத்துவ பரிசோதனை கட்டணத்தை நீங்கள் கொடுக்க வேண்டும் என்பதை தெரிவித்துக்கொள்கிறோம்.

3. பரிசோதனைக்கு செல்லும் போது பின் வருவனவற்றை எடுத்துச் செல்லுங்கள்:
   - பூர்த்தி செய்த கோரிக்கை படிவம்
   - உங்களிடம் இருக்கிற நோய் தொடர்பான தகவல்கள் (Medical Reports)
   - உட்கொள்ளும் மருந்துகள் (முடிந்தால்)

அனைத்து தகவல்களும் சான்றிதழ்களும் எங்களுக்கு கிடைத்தவுடன் உங்கள் கோரிக்கையை பரிசீலனை செய்து முடிவை உங்களுக்கு தெரியப்படுத்துவோம்.

உங்களுக்கு உதவி தேவைப்பட்டால் தயவு செய்து 1800-248 8888 எண்ணுக்கு அழைக்கவும் அல்லது LifePAClaims-PA@greateasternlife.comஎன்று மின்னஞ்சல் செய்யவும்.

ELDERSHIELD CLAIM FORM

To be completed by the applicant, or if he/she is unable to do so, by an immediate family member / caregiver.

BASIC ELDERSHIELD Policy No.: _____ Insurer: Aviva Ltd / Great Eastern / NTUC Income*

SUPPLEMENTARY ELDERSHIELD Policy No.: _____ Insurer: Aviva Ltd / Great Eastern / NTUC Income*

PERSONAL PARTICULARS

APPLICANT

Name of Applicant

Gender
Male / Female*

NRIC No.	Nationality	Date of Birth (DD / MM / YYYY)	Ethnic Group Chinese / Malay / Indian / Others*	

Address

Contact Number (Home) (Handphone)	Email

CAREGIVER

Name of Main Caregiver (Full-time / Part-time*)

Relationship to Applicant	NRIC No.
Contact Number (Home) (Handphone)	Email

BANK ACCOUNT DETAILS (IMPORTANT - Please do not leave blank)

Please pay to the following bank account of the applicant once the claim is admitted.

Name of Bank Account Holder+	Bank Account No.
Name of Bank	Name of Branch

+ For payment to third party (family member / caregiver), please indicate the name of intended payee in the box “Name of Bank Account Holder” above and complete the attached Letter of Undertaking & Indemnity.

MEDICAL HISTORY

1. Have you ever been admitted to hospital in the last 5 years? YES / NO*

   If “YES”, please give details of the medical conditions and when it started.

Condition	Date Started

* Please delete accordingly

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2. Please state other medical conditions, if any (e.g. stroke, hypertension, heart disease, diabetes mellitus), that you are suffering from.

3. Name and address of your regular doctor.

4. If disability is due to accident, please provide date of accident: _____ / _____ / _____ (dd/mm/yyyy), and attach a copy of accident report. If no report is available, please describe: (a) nature of accident, and (b) extent of injuries sustained.

ACTIVITIES OF DAILY LIVING	
Please tick against the box that most accurately describe the applicant's ability	Date Disability Started
1. Washing or bathing - Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. ☐ No help is needed. ☐ Some help / supervision is needed (e.g. to wash the back, to wash hair). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be washed or bathed entirely by caregiver).	
2. Dressing - Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances. ☐ No help is needed. ☐ Some help / supervision is needed (e.g. to button clothes, to put on trousers). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be dressed entirely by caregiver).	
3. Feeding - Ability to feed oneself food after it has been prepared and made available. ☐ No help is needed. ☐ Some help / supervision is needed (e.g. to scoop food, to put food in mouth). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs caregiver to feed entirely or is tube-fed).	
4. Toileting - Ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate. ☐ No help is needed. ☐ Some help / supervision is needed (e.g. to get on or off the toilet). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be placed on the toilet and cleaned by caregiver). ☐ Not able to do at all (needs caregiver to manager diapers and/or catheter).	
5. Transferring - Ability to move from a bed to an upright chair or wheelchair, and vice versa. ☐ No help is needed. ☐ Some help / supervision is needed (e.g. to be lifted up from lying position to sitting position from bed). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be carried).	
6. Mobility - Ability to move indoor from room to room on level surfaces. ☐ No help is needed. ☐ Some help / supervision is needed (e.g. to be supervised by someone closely in case of fall). ☐ Needs someone to help most of the time. ☐ Not able to do at all (needs to be carried).	

* Please delete accordingly

DECLARATION

If the claimant has previously been assessed by a doctor to lack mental capacity*, the claimant's appointed donee(s)/deputy(s), or caregiver if a donee(s)/deputy(s) has not been appointed, is to complete this section and sign/affix thumbprint. The mentally incpacitated claimant need not sign off/affix thumbprint.

*A separate doctor's memo should be submitted to indicate that the claimant lack mental capacity, including the relevant medical reason(s).

I/We,declared that I/We am/are not an undischarged bankrupt or insolvent or has/have executed any deed or transfer for the benefit of creditors within the last twelve (12) months.

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.

I further agree that this declaration shall form part of my proposed application for Eldershield benefits, and a copy of this form shall be treated as valid and binding as if it were the original.

Name of Applicant	NRIC No.	Signature / Thumb Print of Applicant	Date

To be completed if form is filled up by family members / caregiver	
Name of family member / caregiver*	Signature of family member / caregiver*
Relationship to Applicant	Date

* Please delete accordingly

The Manager
Claims Department
The Great Eastern Life Assurance Company Limited
1 Pickering Street #13-01
Great Eastern Centre
Singapore 048659

Policy No. _____

PART I: LETTER OF UNDERTAKING & INDEMNITY

I/We declare that I am/we are the main caregiver of the Policyholder, _____
NRIC No. _____ .

In consideration of The Company agreeing or having agreed, at the Policyholder's/my/our request to pay the benefits, which the Policyholder is entitled to under the ElderShield policy, to me/us, I/we agree and undertake as follows:-

1. That I/we will use and apply the ElderShield benefits paid by The Company only for the care and benefit of the Policyholder.

2. That I/we will inform The Company immediately upon becoming aware that the Policyholder recovers from the disability, which refers to the inability to perform at least 3 Activities of Daily Living, or passes away.

3. That I/we will repay any ElderShield benefits, which the Policyholder is not entitled or ceases to be entitled to, upon written demand by The Company. I/we agree and undertake that if I/we fail to make such repayment, I/we will fully indemnify The Company against any loss, damage, cost and expenses whatsoever, including any legal cost, which may be incurred by The Company as a result of my/our failing to fully repay the ElderShield benefits or of The Company's need to enforce its rights under the Undertaking or Indemnity.

PART II: LETTER OF UNDERTAKING & INDEMNITY FOR PIONEER GENERATION DISABILITY ASSISTANCE SCHEME (PIONEER DAS)

This Part applies where the Policyholder/Applicant named in Part I ("Pioneer") is determined to be eligible for and is accepted into the Pioneer Generation Disability Assistance Scheme (PioneerDAS)*, a Government scheme administered by the Agency for Integrated Care (AIC).

To: the Government of the Republic of Singapore
- I/We declare that I am/we are the main caregiver(s) of the Pioneer.
- I/We agree and undertake as follows:
- I/We will use the PioneerDAS payments only for the care and benefit of the Pioneer.
- I/We will inform AIC immediately in writing if the Pioneer has passed on or ceases to satisfy the PioneerDAS Eligibility Criteria*
- Upon written demand by AIC, I/ we will refund to AIC any PioneerDAS payments paid after the Pioneer ceases to be eligible for such payments.
- I/We will fully indemnify AIC and the Government of the Republic of Singapore against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred as a result of my failing to abide by the terms of this Undertaking and Indemnity.

* Eligibility Criteria for PioneerDAS is as follows:
- The Pioneer is born on or before 31 December 1949;
- The Pioneer is a citizen of Singapore on or before 31 December 1986, and remains a Singapore citizen;
- The Pioneer continues to stay in Singapore; and
- The Pioneer continues to require assistance with at least 3 out of 6 Activities of Daily Living (ADLs): (i) showering/bathing; (ii) dressing; (iii) eating; (iv) toileting; (v) transferring from chair to bed or vice versa; and (vi) walking or moving on level surfaces.

For more information on PioneerDAS, please refer to AIC at 1800-650-6060 (Mon to Fri 8.30am – 6pm, Sat 8.30am – 12.30pm) or pioneerDAS@aic.sg

** Singaporeans who are members of the Pioneer Generation and who meet the criteria to qualify for basic ElderShield/ IDAPE payouts will automatically be included in PioneerDAS.*

PART III: DIRECT CREDIT AUTHORISATION

I hereby authorise The Company to credit the ElderShield benefits that are payable to the policyholder under the ElderShield policy into this account and verify my account with the bank.

Account Name(s) : _____

NRIC No. (if applicable) : _____

Name of Bank : _____

Branch : _____

Account No. : _____

I hereby enclose a copy of the first page of the Bank Account Passbook / top portion of Bank Statement, showing my account particulars for process of the above direct crediting.

I/We 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/We hereby confirm and represent to The Company that I/We have the authority to provide consent on behalf of the Policyholder.

I/We hereby agree and consent to The Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my/our/the Policyholder'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 process and administer the Policyholder's claims.

These purposes are set out in The Company's Privacy Statement, which is accessible at http://www.greateasternlife.com/sg/en/pncpolicies.htm and which I/We confirm I/We 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 the Policyholder from any persons possessing the same (such as doctors whom the Policyholder has consulted), and I/We hereby authorise those persons to release the same to any of the Requesting Parties for the purpose of the Policyholder's claims, and

(b) the Requesting Parties may disclose any relevant information concerning the Policyholder (including the Policyholder's medical information) to other parties, which any of the Requesting Parties deems necessary for the purpose of the Policyholder's claims.

I/We further agree that this declaration shall form part of /our/the Policyholder's proposed application for Eldershield benefits, and a copy of this form shall be treated as valid and binding as if it were the original.

Full Name	NRIC No.
Signature & Date	Relationship to Applicant
For Homes / Institutions ONLY (if benefits are to be made to the Home /Institution)	
Name of Authorised Officer	Official Stamp of Home / Institution
Signature & Date	

To be completed if form is filled up by family members / caregiver	
Name of family member / caregiver*	Signature of family member / caregiver*
Relationship to Applicant	Date

"The Company" refers to The Great Eastern Life Assurance Company Limited.

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