ELDERSHIELD / CARESHIELD CLAIMANT'S STATEMENT

Great Eastern
A member of the OCBC Group

Important Note:

1 The Great Eastern Life Assurance Company is hereby referred to as "The Company".
2 To be completed by the Policyholder. Date format in dd/mm/yy. Submit this together with relevant tests.
3 All eligible policies will be processed together, unless the Company being informed otherwise.
4 Please ensure your contact details with the Company, including mobile no. and email address are updated to receive your correspondences.

* Please tick where appropriate.

1 Details of Policyholder / Life Assured

Full Name: _____ NRIC / Passport No.(for foreigner only): ☐☐☐☐☐☐☐☐☐☐☐☐

Details of Life Assured (if different from Policyholder)

Full Name: _____ NRIC / Passport No.(for foreigner only): ☐☐☐☐☐☐☐☐☐☐☐☐

Contact Number: (Home) _____ (Mobile) _____

Address: _____

2 Details of Claim and Medical Consultation History

a) Date symptoms first appeared: _____

Describe symptoms in full: _____

Details of accident, if applicable: _____

b) Date first consulted a doctor: _____

Name and Address of Doctor: _____

Treatment and Advice given: _____

c) Date condition first diagnosed: _____

Full and exact diagnosis: _____

Name and Address of Doctor: _____

d) Details of other doctors whom the Life Assured consulted for this condition (or similar condition is the past):

Date of Consultation	Diagnosis	Name & Address of Doctor Consulted

e) Does the Life Assured suffer from any other medical condition or disability? ☐ Yes ☐ No

If "YES", please give details.

Date First Diagnosed	Medical Condition/Disability	Name & Address of Doctor Consulted

3 Other Insurance

Is the Life Assured insured with other insurance company? ☐ Yes ☐ No

If "Yes", please give details.

Date of Issue	Name of Insurer	Type of Plan	Sum Assured (S$)	Claim Notified

_____ Signature of Claimant

_____ Date

4 Activities of Daily Living

Please tick against the box that most accurately describe the applicant's ability	Date Disability Started
1 Washing - The 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 - The ability to put on, take off, secure and unfasten all garments 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 - The 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 -The 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 which require assistance and needs caregiver to manage 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 Walking or Moving Around - The 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

5 Settlement Option - Please do not leave blank and tick one option.

☐ PayNow up to S$200,000

By selecting this option, 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 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.

☐ Direct Credit up to S$10,000

By selecting this option, I confirm that I have provided my bank statement or bank book for verification purpose. For the payment to third party (family member/caregiver), please complete the attached Letter of Undertaking & Indemnity and attach a copy of the bank statement or bank book.

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

DECLARATION

Note: 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 incapacitated 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)

1) 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 creditor within the last twelve (12) months.
2) 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.
3) 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://greateasternlife.com/sg/en/privacy-and-security-policy.html* and which I confirm I have read and understood, including without limitation:

(i) 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

(ii) 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 Supplements or GREAT CareShield benefits, agree Great Eastern's Privacy Statement and a copy of this form treated as valid and binding as if it were the original.

Name of Application	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
Address	Contact Number

The Manager
Claims Department

The Great Eastern Life Assurance Company Limited 1 Pickering Street #01-01
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 _____

(Name of Policyholder) of NRIC No. _____, Policy No (s). _____

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 Supplements / GREAT CareShield policy ("Benefits"), to me / us, I / We agree and undertake as follows:-

1. That I / We will first use the Benefits paid by The Company for the Policyholder's care.

2. That I / We will inform The Company immediately upon becoming aware that the Policyholder recovers from the disability, or passes away.

3. That I / We repay any 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 Benefits or of The Company's need to enforce its rights under the Undertaking or Indemnity.

4. 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.

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

6. 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.

7. These purposes are set out in Great Eastern's Privacy Statement, which is accessible at *http://greateasternlife.com/sg/en/privacy-and-security-policy.html* 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.

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

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

PART II: DIRECT CREDIT AUTHORISATION

Please attach a copy of the Bank Bank or Statement showing the bank's name, branch and account number and a copy of all the account holder(s)'s NRIC for our action.

I/We hereby authorise The Company to credit the Benefits that are payable to the policyholder under the Benefits into this account and verify my account with the bank.

Name of Bank Account Holder(s)	NRIC No.
Name of Bank	Name of Branch
Bank Account Number	

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
Address	Contact Number