





**8 ACCIDENT (IF APPLICABLE)**

- (a) Date of Accident: 

D	y	Month	Year

 (b) Time of Accident: \_\_\_\_\_
- (c) Place of Accident: \_\_\_\_\_
- (d) Detailed description of Accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- (e) Name(s) and telephone no(s) of witness(es):

Name of Witness	Telephone No.

**9 HOSPITALISATION**

- (a) How was the Life Assured admitted to the hospital? [ please tick ]
- Referral by a General Practitioner/ Specialist/ Other Hospital\*
- Please provide the name and address of doctor/hospital: \_\_\_\_\_  
 \_\_\_\_\_
- A & E department

**10 DETAILS OF REGULAR DOCTOR(S)**

- (a) Name(s) and address(es) of the Life Assured's regular/ company doctor(s):

Name(s)	Address(es)	Date(s) of Consultation	Reason(s) for Consultation

- (b) (i) Does the Life Assured have the same medical condition previously or any other medical conditions not stated above? YES / NO\*
- (ii) If "YES", please state:

Date of Onset: 

D	y	Month	Year

Date of Diagnosis: 

D	y	Month	Year

Medical condition: \_\_\_\_\_

Medical treatment received: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Policyholder

**11 OTHER INSURANCE**

Is the Life Assured claiming for medical expenses from any other sources (e.g. employer, other medical insurances)? YES / NO\*  
If "YES", please provide the following information.

Note: The following information provided shall apply to the organ donor if he/she shall be eligible for reimbursement under his/her own medical insurance in the event that you are claiming for Living Donor Organ Transplant benefit under Supreme Health / Total Health policy.

Name of Employer, Insurance Company, etc	Date of Issue	Type of Plan	Claim Amount	Claim Notified (YES/ NO*)

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 <https://www.greasternlife.com/sg/en/privacy-and-security-policy.html> 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. By providing the details of my bank account in Section 3 above, I hereby authorise Great Eastern to credit any claim proceeds of not more than S\$10,000 into the aforesaid bank account.

\_\_\_\_\_  
Signature of Policyholder

Name: \_\_\_\_\_

NRIC/ Passport No: \_\_\_\_\_

Date: \_\_\_\_\_