Great Eastern General Insurance Limited (Reg. No. 1920 00003W)
(A wholly-owned subsidiary of Great Eastern Holdings Limited)
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659
Tel +65 6248 2638 Fax +65 6327 3014 greateasterngeneral.com

Great Eastern
A member of the OCBC Group

PERSONAL ACCIDENT CLAIM FORM

Please state as fully and accurately as possible the information asked for below and to return this form immediately to Great Eastern General Insurance Limited ("Company") with original final bills/receipts. The acceptance of this form is not in itself an admission of liability on the part of the Company.

Event Name: Great Eastern Women's Run 2019

SECTION A - CLAIM INFORMATION

Name of Insured:	Tag No.:	NRIC No.:	Policy No.:
Address:		Sex: Male / Female	Contact No.:
		Email Address:	
1. Name of Claimant:		2. Date of Birth:	3. Gender: Male/Female
4. Present occupation (*if more than one, state all*).			
5. Exact nature of occupational duties and monthly earnings.			
6. Name, Address of business or employer.			
7. Date and Time of Accident.		Date: _____ (D/M/Y) Time:_____	
8. Nature of Accident (*Describe in details, how & where it happened*).			
9. Describe in details the injuries sustained, indicating the part of the body injured and the type of injury (*eg. fracture, cut, bruise, etc.*)			
10. Name and Address of doctor(s) who treated you and consultation date(s).			
11. Details of Hospitalisation (*Attach discharge note & hospital bill*): (a) Name of hospital (b) Period of hospitalisation		(a) (b) Date Admitted: _____ Date Discharged: _____	
12. Date last worked prior to disability.			
13. Date returned/expected to return to work.			
14. How long have you been totally or partially disabled from engaging in or attending to your usual business as a result of the injuries?			
15. Name and Address of any witness of the incident.			
16. Name and Address of your usual family doctor.			

17. Are you claiming from any other insurance company or other sources in respect of this injury? If yes, state:

Name of Insurance Company	Policy No.	Amount of Benefits	Date Insurance Effected

DECLARATION AND AUTHORISATION

I/We hereby declare that the particulars stated above are true and correct in every detail and I/we agree that if I/we have made or in any further declaration in respect of the same claim shall make any false or fraudulent statements or suppress conceal or falsely state any material fact whatsoever the relevant insurance policies shall be void and and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Without prejudice to the consent given below in respect of my/our personal data, I/we here authorize any hospital physician, other person who has attended or examined me/us, to furnish to the Company, or its authorised representatives, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A copy of this authorisation shall be considered as effective and valid as the original.

PERSONAL DATA

In addition to the declaration and authorisation provided above, I/we 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 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, admin, process and/or administer my/our 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/we confirm I/we have read and understood.

_____	_____
Insured/Claimant's Signature / Date	Verified by Employer (if applicable)

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N.B. No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form below be furnished at the expense of the Insured.

SECTION B - ATTENDING DOCTOR'S STATEMENT

1. Name of Patient	2. NRIC No.	3. Date of Birth
4. Date on which you first saw the patient.		
5. Is condition due to Injury or Sickness?	☐ Sickness ☐ Accident on _____(D/M/Y)	
6. Was the patient referred to you by another doctor? If so, please furnish Name and Address of referral doctor.		
7. (a) Of what symptoms did the patient complain? (b) According to the patient, how long had he/she been experiencing these symptoms?	(a) (b)	
8. In your opinion, how long do you feel the symptoms had lasted?		
9. Had the patient previously seen any other doctor or receive treatment on account of these symptoms? If so, please give details.		
10. (a) What is your final diagnosis? (b) Does injury results in fracture of bones? If yes, which part of the body?	(a) (b) ☐ No ☐ Yes, _____ Simple Fracture ☐ Compound Fracture ☐	
11. Did Injury or Sickness require: (a) Hospitalisation? (b) X-rays? (c) Special diagnostic procedure? (d) Surgery?	(a) ☐ No ☐ Yes Date Admitted: _____ Date Discharged: _____ (b) ☐ No ☐ Yes (c) ☐ No ☐ Yes (d) ☐ No ☐ Yes Type of Surgery: _____	
12. Is patient still under your care for this condition?	☐ No ☐ Yes	
13. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him from working?		
14. How long was or will patient be continuously totally disabled (*unable to work*)?		
15. How long was or will patient be partially disabled?		
16. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.		

I hereby certify that I have personally examined and treated the patient for the above *injury/sickness and that the facts as given above present my opinion of his/her condition.

Name of Doctor: _____

Date: _____

* to delete as applicable

_____
Signature & Official Stamp of Doctor