

DOMESTIC MAID 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.

A - INSURED'S DETAILS			
Name of Insured	NRIC No.	Policy No.	
Address	Sex: Male / Female	Contact No.	
	Email		
B - INSURED PERSON'S DETAILS			
Name of Insured Person	FIN/Passport No.	Nationality	Date of Birth
Date of Employment	Monthly Salary	Monthly Levy	
C. SICKNESS			
Describe Nature of Sickness	Date First Began	Date First Treated	
Has the sickness been treated previously? If Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state date of previous treatment.			
Is the sickness due to pregnancy, abortion, sterilization or infertility? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please specify condition & appropriate date of commencement.			
D. INJURY			
Date of Accident	Time of Accident	Is this a job-related Accident?	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Describe How & Where Accident Happened			
E. OTHER INFORMATION			
Name of Hospital / Clinic	Address of Hospital / Clinic	Name of Attending Doctor	
Date of Admission	Date of Surgery performed	Date of Discharge	
Is the patient entitled to claim for this treatment against any other insurance policies? If yes, please indicate the name of the insurance company and details of insurance (eg. type, policy no. etc).			

F. SETTLEMENT OPTION

Direct settlement to hospital

PayNow (registered with NRIC/ FIN only)

PayNow is the default settlement option up to S\$200,000 for policyholder who has registered with PayNow and has linked his/ her Singapore NRIC/valid FIN to the bank account ("PayNow Account"). You hereby authorise and instruct The Company to deposit the payment that is payable to you into your PayNow Account as well as verify your PayNow Account with the respective Bank ("where necessary").

Credit into my personal bank account.

Name of Bank	Branch of Bank	Bank Account Number	Account Holder's Name

Claim amounts will only be direct credited to the Policyholder's bank account. Please provide a copy of your recently issued bank statement/ passbook/ e-statement showing your full name, ID/ address, bank name, branch and account number (with transaction and other details blanked out) for verification. Direct crediting will only be applicable for claims (excluding reimbursement to CPF Board) to a local bank account.

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 I/We shall have no rights to make any claims (whether past or future) 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 hereby authorise 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, admit, process and/or administer my/our claims.

These purposes are set out in Great Eastern's Privacy Statement, which is accessible at <https://www.greatasterlife.com/sg/en/privacy-and-security-policy.html> and which I/we confirm I/we have read and understood.

Insured Person's Signature / Date

Insured's Signature / Date

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.

G - ATTENDING DOCTOR'S STATEMENT		
1. Name of Patient	2. FIN/Passport No.	3. Date of Birth
4. (a) If Injury: When did Accident occur? (b) If Sickness: When did symptoms first appear?	(a) (b)	
5. (a) State the Nature of Injury or Sickness (Describe complications - If any) (b) Final Diagnosis. (c) Nature of Surgery (if any)	(a) (b) (c)	
6. (a) When did the Patient first receive medical attention for this condition? (b) By Whom? Name of Doctor. (c) Address	(a) (b) (c)	
7. Has the Patient ever had this or any similar condition?	<input type="checkbox"/> No Yes, details: _____ _____ _____	
8. Is the present condition of patient due to: (a) congenital anomaly? (b) nervous or mental disorder? (c) pregnancy/childbirth/infertility? (d) alcohol influence?	(a) No Yes, specify: _____ (b) No Yes, specify: _____ (c) No Yes, specify: _____ (d) No Yes, specify: _____	
9. Period of Hospitalisation.	Date Admitted: _____ Date Discharged: _____	
10. Name and Address of Hospital Admitted.		
11. Are you the Patient's usual Doctor?	(a) No Yes If no, name and address of usual Doctor: _____ _____	
<p>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.</p> <p>Name of Doctor: _____</p> <p>Date: _____</p> <p style="text-align: right;">_____ Signature & Official Stamp of Doctor</p> <p><small>* to delete as applicable</small></p>		