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? ☐ Yes ☐ No
If yes, please state date of previous treatment.

Is the sickness due to pregnancy, abortion, sterilization or infertility? ☐ Yes ☐ No
If Yes, please specify condition & appropriate date of commencement.

D. INJURY

Date of Accident	Time of Accident	Is this a job-related Accident? ☐ Yes ☐ No

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").

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 ot 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.greateasternlife.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?	☐ 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: _____ _____	

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: _____

_____
Signature & Official Stamp of Doctor

* to delete as applicable