FOREIGN WORKER MEDICAL INSURANCE (HGG) CLAIM

Please state as fully and accurately as possible the information asked for below and to return this form immediately to the Company with supporting documents. The acceptance of this form is not in itself an admission of liability on the part of the Company.

CLAIM SUBMISSION PROCEDURES

Please read carefully before you complete the attached Claim Form.

1. The Great Eastern General Insurance Limited ("Company") does not admit liability by the mere issue of this Form.
2. Please complete and answer all questions in full and circle the appropriate boxes provided. Please indicate "N.A.", if the question is not applicable in your case.
3. Please submit the Claim Form and all claim documents (see below) within 30 days from the date of discharge from hospital or date of surgery.
4. Please submit only original final itemised bills (not summarized bills) and receipts. Photocopies of bills/receipts are NOT acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.
5. Please include a copy of work permit or employment pass for claim processing.

CLAIM DISCHARGE

If the Company admits liability and makes payment to the payee indicated on Part I - Statement by Policyholder (Employer), acceptance of our cheque will fully discharge the Company of all liabilities in respect of this claim.

PART I – STATEMENT BY INSURED (EMPLOYER)

NAME OF EMPLOYER (INSURED)	POLICY NO.	UNION MEMBER? YES ☐ NO ☐
EMAIL ADDRESS (Acknowledgement of receipt of claim will be provided through email only)		
NAME OF EMPLOYEE (INSURED PERSON)		EMPLOYEE'S COMMENCEMENT DATE OF INSURANCE: (DD/MM/YYYY)
MALE ☐ FEMALE ☐	OCCUPATION:	EMPLOYEE'S DATE OF EMPLOYMENT: (DD/MM/YYYY)
NRIC/FIN NO.	DATE OF BIRTH: (DD/MM/YYYY)	PLAN TYPE:

PART II - STATEMENT BY INSURED PERSON (EMPLOYEE)

NAME		DATE OF HOSPITALISATION / SUGERY: (DD/MM/YYYY)	
NRIC / FIN NO.	DATE OF BIRTH: (DD/MM/YYYY)	MALE ☐ FEMALE ☐	TOTAL AMOUNT INCURRED:

SICKNESS

DIAGNOSIS / SYMPTOMS	DATE SICKNESS 1st BEGAN (DD/MM/YYYY)
HAS THIS CONDITION BEEN TREATED PREVIOUSLY? YES ☐ NO ☐	DATE 1st TREATED: (DD/MM/YYYY)
NAME OF DOCTOR	ADDRESS OF DOCTOR'S CLINIC
DID THIS DOCTOR REFER YOU ON HIS OWN ACCORD TO THE SPECIALIST WHO IS NOW TREATING YOU? (If yes, please attach Doctor's referral letter)	YES ☐ NO ☐

ACCIDENT

DATE & TIME OF ACCIDENT:
DETAILED DESCRIPTION ON HOW THE ACCIDENT HAPPENED AND STATE THE EXTENT OF INJURY:
IS THE ACCIDENT WORK-RELATED? YES ☐ NO ☐
ARE YOU MAKING A CLAIM FROM OTHER INSURANCE COMPANIES? YES ☐ NO ☐ (If yes, please submit a copy of the other insurance company's claim settlement letter/payment voucher)

PART III – 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 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.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I/we confirm I/we have read and understood.

_____
Signature of Insured Person / Date

_____
Signature of Insured / Date
(Please provide Company Stamp)

PART IV – DOCTOR'S STATEMENT (TO BE COMPLETED BY ATTENDING DOCTOR)

INSURED/EMPLOYER must bear the fee charged, if any, for the completion of this medical report. The Company will not reimburse any part of this fee.

PATIENT'S FULL NAME	NRIC / FIN NO.	DATE OF BIRTH (DD/MM/YYYY)
NAME OF THE HOSPITAL ADMITTED	DATE OF ADMISSION (DD/MM/YYYY)	DATE OF DISCHARGE (DD/MM/YYYY)
Please state the diagnosis of all medical conditions treated and symptoms of illness or injury.		DATE OF DIAGNOSIS (DD/MM/YYYY)
Please give the date of onset and duration of complaints. If no complaints, please state reasons for seeking medical attention.		DATE OF 1ST CONSULTATION (DD/MM/YYYY)
Please give dates of previous treatment if patient has a history of these complaint(s) before.(DD/MM/YYYY)		
Please give the names and address of the doctor who treated the patient previously or referred the patient to you.		
Please state the patient's diagnosis		1st diagnosed date (DD/MM/YYYY)
If there are more than 1 diagnosis, kindly advise whether if they are related directly or indirectly to each other. Please explain.		YES ☐ NO ☐
What is the underlying cause(s)?		Diagnosed Date (DD/MM/YYYY)
Was the treatment provided to the patient for: a) Congenital anomaly? b) Self-inflicted injuries or alchoholism or drug addiction? c) Mental or Psychiatric disorder? d) Pregnancy or Childbirth related complications?		If yes, please state: ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO**
Type of operation(s) / surgical procedure(s) performed		Date Performed (DD/MM/YYYY)
Please indicate treatment rendered if no surgery was done.		

Signature of Doctor / Surgeon
Full Name:
Date:

Address and Qualification of Doctor / Surgeon

(Please affix Doctor's Stamp)