Dear Claimant,

We are sorry to learn of your disability.

In order for us to process the Permanent Disability Claim, we require the following:-

1) Claimant's Statement.
2) Clinical Abstract Application Form.
3) Doctor's Statement (refer to Note I below).
4) Authorisation Letter (refer to Note II below).
5) All available Laboratory and Test Results.
6) Medical Report fee receipt.

Once we have received all the above required documents, we will process your claim and inform you of the outcome as soon as possible.

If you need any help, please call our Customer Service hotline at 1800-248 2888 or email us at claims-sg@greateasternlife.com.

Note:

I) The Doctor’s Statement must be completed by your attending doctor and submit together with the rest of the claims documents listed above. You may attach the Medical Report fee receipt and we would reimburse you the medical report fee (as provided under DPS).

II) Authorisation letter has to be submitted if you are authorising another party to handle the claim (including collection of cheque) on your behalf.

III) Please continue to pay your premiums until we inform you that the claim is admitted.

Submission of Documents

Please submit all claim documents personally at our Customer Service Centre at the ground floor, Great Eastern Centre or, through your Servicing Life Planner or, by post to:

Claims Department
The Great Eastern Life Assurance Company Limited
1 Pickering Street
Great Eastern Centre #13-01
Singapore 048659
**AUTHORISATION LETTER**

**For Claimant’s completion:**

I would like the claim cheque (if claim is approved) to be:

- [ ] posted to me via my correspondence address.
- [ ] collected by my Servicing Life Planner, __________________________ (NRIC No.: ____________)

Signature of Claimant: __________________________ Policy No.: __________________________

Name of Claimant: __________________________ NRIC of Claimant: __________________________

Handphone/ Contact No. of Claimant: __________________________ Date: __________________________

**For Servicing Life Planner’s completion (if Claimant has authorised you to collect the cheque)**

I would like the claim cheque to be:

- [ ] Collected at Customer Service Reception Counter at Ground Floor, Great Eastern Centre.
  (Please note that the cheque will be posted to the Claimant if it is not collected by the next working day after the collection date.)
- [ ] Dropped into my GSM Box No. _______ at GE@Changi.*
- [ ] Dropped into my GSM Box No. _______ at GE House.*
- [ ] Dropped into my GSM Box No. _______ at Nankin Row.*

* Notes:-
1. Option is available only if there are no outstanding documents to be submitted. Cheque will be delivered to your GSM Box the next working day after 12pm.
2. For Life Planners who have opted for collection of cheques at Customer Service Reception Counter at Great Eastern Centre, Claims Department will contact you when the cheque is ready.

Signature of Servicing Life Planner: __________________________ Agent No.: __________________________

Name of Servicing Life Planner: __________________________ Contact No.: __________________________

**For Official Use:**

Claim Officer: __________________________ Extension No.: __________________________

Pending documents / comments:

Cheque / Letter released by:-

Signature: __________________________ Name: __________________________ Date: __________________________

Cheque / Letter received by:-

Signature: __________________________ Name: __________________________ Date: __________________________

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
The Overseas Assurance Corporation Limited (Reg No. 1920 00011W)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: claims-sg@greateasternlife.com  Website: greateasternlife.com

Oct 2012
Dear Sir

Name of Patient: ___________________________________________________________________________ NRIC No.: __________________________

Re: Application for Medical Report

I hereby authorise you to furnish THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED/ THE OVERSEAS ASSURANCE CORPORATION LIMITED with a detailed medical report on the above named patient (including without limitation all of my personal data contained therein) for purposes reasonably required by any of the aforesaid companies to evaluate, admit, process and/or administer my insurance claims. I agree and confirm that a photocopy of this executed Clinical Abstract Application form is as valid and effective as the original Clinical Abstract Application form.

Yours faithfully

[ ] [ ] [ ]

Signature of *Patient / Patient's Parent / Patient's Spouse / Next-Of-Kin

[ ] [ ] [ ]

Signature of witness

Name: ___________________________ Name: ___________________________

NRIC No.: ______________________ NRIC No.: _______________________

Address: ___________________________________ Address: ___________________________________
### DEPENDANTS’ PROTECTION SCHEME (DPS) PERMANENT DISABILITY CLAIM CLAIMANT’S STATEMENT

**Important Note:**
1. The Great Eastern Life Assurance Company Limited hereby referred to as “The Company”.
2. To be completed by the Policyholder.
3. Under Section 3(4) of the CPF (DPS Insurance Scheme) Regulation, the maximum sum for which a member is insured in respect of any incapacity or death which occurred or deemed to have occurred before the implementation date (i.e. before 17 September 2005) shall be $44,000.

* Please delete where appropriate

### 1 POLICY (IES) ISSUED BY THIS COMPANY

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<thead>
<tr>
<th>Great Eastern Life Policy No(s):</th>
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### 2 DETAILS OF POLICYHOLDER (Please complete in BLOCK letters)

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<th>NRIC/Passport No.:</th>
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<th>Occupation:</th>
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<th>E-mail Address:</th>
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Claims Acknowledgement Update via SMS: YES / NO* (Kindly note that this SMS facility is available for Great Eastern Life policies only).

### 3 DETAILS OF LIFE ASSURED (if different from (2)) (Please complete in BLOCK letters)

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<th>Name (According to NRIC/Passport):</th>
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<th>Date of Birth (dd/mm/yyyy):</th>
<th>Gender: M / F *</th>
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<th>E-mail Address:</th>
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### 4 DETAILS OF LIFE ASSURED’S OCCUPATION

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<th>Occupation:</th>
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<th>Before Disability</th>
<th>After Disability</th>
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(b) Name of employer:

(c) Average monthly income for 1 year:

(d) List exact duties performed at work (see Note):

Note: If the Life Assured is not working, provide a list of daily activities before and after the disability.

Date ____________________________

Signature of Policyholder ____________________________
5 DETAILS OF DISABILITY

(a) If the disability suffered is due to illness, please provide:

(i) Date symptoms started: ____________

(ii) Describe in detail all symptoms presented: __________________________________________

(b) If the disability suffered is due to accident, please provide:

(i) Date of accident: ____________

(ii) Time of accident: ______________________

(iii) Place of Accident: __________________________

(iv) Detailed description of the Accident:

____________________________________________________________________________________

(v) Detailed description of the injuries:

____________________________________________________________________________________

(vi) Was the accident reported to the police? YES / NO *

If YES, please provide the name of police division and police officer-in-charge's name.

____________________________________________________________________________________

(Please enclose a copy of the police report.)

(c) Date the Life Assured last worked: ____________

(d) Is the Life Assured currently confined to: Bed / House / Neither *

(e) Date the Life Assured returned to work: ____________

or

Date the Life Assured is expected to return to work: ____________

____________________________________________________________________________________

Date ________________________________ Signature of Policyholder ____________________________
### 6 DETAILS OF PHYSICIAN(S) CONSULTEO OR HOSPITAL(S) ADMITTED FOR THIS DISABILITY

<table>
<thead>
<tr>
<th>Name(s)</th>
<th>Address(es)</th>
<th>Date(s) of Consultation / Hospitalisation</th>
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### 7 DETAILS OF REGULAR PHYSICIAN(S)

Details of the Life Assured’s regular physician or any other physician(s) consulted for other disorders in the past three years.

<table>
<thead>
<tr>
<th>Name(s)</th>
<th>Address(es)</th>
<th>Reason for Consultation</th>
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### 8 OTHER INFORMATION

Has the Life Assured or the Claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy?  
**YES / NO**

### 9 OTHER INSURANCE

Is the Life Assured claiming from any other insurance company or other sources in respect of this disability?  
**YES / NO**

If “YES”, provide the following information.

<table>
<thead>
<tr>
<th>Name of Employer/ Insurer</th>
<th>Date of Issue</th>
<th>Type of Plan</th>
<th>Claim Amount</th>
<th>Claim Notified (YES/ NO)</th>
<th>Claim Paid (YES/ NO)</th>
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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 http://www.greateasternlife.com/sg/en/pncpolicies.htm 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. This includes without limitation disclosure to the board of Central Provident Fund (“Board”) for purposes of (i) making of a claim under the Dependents’ Protection Insurance Scheme or any other insurance scheme referred to in the Central Provident Fund Act (Chapter 36) of Singapore which I may be insured under; and (iii) the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act (Chapter 36) of Singapore.

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. I am aware that the claim amount (if payable) is based on the amount of benefits under the relevant policy as at the date of permanent incapacity.

__________________________
Signature of Policyholder

Name: ________________________________

NRIC/ Passport No: ________________________________

Date: ________________________________
PERMANENT DISABILITY CLAIM

DOCTOR’S STATEMENT

* Please delete where appropriate

For Official Use

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Name of Life Assured: ____________________________

NRIC/ Passport No.: ____________________________ Date of Birth (dd/mm/yyyy): ____________________________ Gender: M / F *

1. (a) Are you the Life Assured’s regular doctor? YES / NO*

If “YES”, since what date?

2. (a) Date of first consultation for the current condition:

(b) Date of subsequent consultation(s): ____________________________

(c) Please state the symptoms presented and date symptoms first appeared.

<table>
<thead>
<tr>
<th>Symptoms Presented at First Consultation</th>
<th>Date Symptoms First Started (DD/MM/YY)</th>
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What is the source of this information? Life Assured/ Referring Doctor/ Others

If “Others”, please specify the name of the person and relationship to the Life Assured:

(d) Diagnosis: ____________________________

(e) Date of FIRST Diagnosis:

(f) Diagnosis was first made by (name of doctor): ____________________________

(g) Date diagnosis was made to the Life Assured:

(h) What was the exact information conveyed to the Life Assured?

3. (a) Life Assured’s occupation before disability:

Date ____________________________ Signature of Doctor ____________________________
(b) Nature of duties of current occupation.

______________________________________________________________________________

(c) How does the Life Assured’s disability prevent him/ her from performing the above listed duties of his/ her occupation?

______________________________________________________________________________

4. (a) Is the condition a result of an accident? YES / NO*

If “YES”, please state the date of accident: ______ Day ______ Month ______ Year ______

Time of accident: ____________________________

Describe in detail how the accident happened.

______________________________________________________________________________

(b) Was the accident reported to the police? YES / NO*

If “YES”, please provide the name of the police division and the police officer-in-charge’s name.

(Please enclose a copy of the police report.)

______________________________________________________________________________

(c) Was the Life Assured under the influence of alcohol/ drugs at the time of accident? YES / NO*

If “YES”, please state the blood alcohol content/ drug type and quality consumed: ____________________________

______________________________________________________________________________

(d) Is the condition self-inflicted? YES / NO*

If “YES”, please provide full details.

______________________________________________________________________________

(e) Type of treatment including any operations performed and his/ her response.

______________________________________________________________________________

5. (a) Please describe fully the nature and severity of the Life Assured’s disabilities.

______________________________________________________________________________

______________________________________________________________________________

Date ________________________ Signature of Doctor ____________________

Jun 2014
(b) Is his/her disability progressive, stationary or improving?

(c) Is full recovery expected?  YES / NO*
   If “YES”, please state approximate date: Day Month Year
   If “NO”, please state the extent of recovery and approximate date.

(d) Is the Life Assured able to perform all the 6 Activities of Daily Living (ADL) without assistance?  YES / NO*
   The 6 ADLs include feeding, mobility, transferring, bathing, dressing and toileting
   If “NO”, please state which one(s) he/she is unable to perform independently.

(e) Is the Life Assured confined to a home, hospital or other institution that provides constant care and medical attention?  YES / NO*
   If “YES”, since what date? Day Month Year

(f) Does the Life Assured have full power of all limbs?  YES / NO*
   If “NO”, please specify which limb(s) do(es) not have full power and the current power of limbs.

(g) Please give full details with respect to the Life Assured’s mental abilities and cognition.

(h) Is the Assured able to perform all the normal duties of his usual occupation?  YES / NO*
   If “YES”, when is he/she expected to return to his usual occupation? Day Month Year

(i) If he/she is unable to return to his/her usual occupation, is he/she able to engage in any other occupation?  YES / NO*
   If “YES”,
   (i) What types of occupation can he/she engage in?
   (ii) When is he/she expected to engage in these occupations? Month Year

Date ___________  Signature of Doctor ___________
6. (a) Did the Life Assured consult other doctors for this illness or its symptoms BEFORE he/she consulted you?  
YES / NO*  
If "YES", please give name(s) and address(es) of the doctor(s) whom he/she consulted.

<table>
<thead>
<tr>
<th>Name of Doctor</th>
<th>Name of Clinic/ Hospital and Address</th>
<th>Date of First Consultation</th>
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(b) Is the Life Assured suffering or has suffered from any other significant illnesses?  
YES / NO*  
If "YES", please state.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Date of First Diagnosis (DD/MM/YY)</th>
<th>Name and Address of Attending Doctor</th>
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(c) (i) Is the Life Assured physically or mentally incapacitated from ever continuing in any employment?  
YES / NO*  
(ii) If Yes, when did such disability commence?  
Day Month Year  
(iii) If the Life Assured is mentally incapacitated, please state if he/she is mentally capable of receiving or handling money.  
YES / NO*  
(d) (i) Is the disability "total and permanent" and such that there is neither than nor at any time thereafter any work, occupation or profession that the person concerned can ever sufficiently do or follow to earn or obtain any wages, compensation or profit?  
YES / NO*  
(ii) If Yes, when did such disability commence?  
Day Month Year  
(e) Is the Life Assured terminally ill?  
YES / NO*  

7. If the incapacity of the Life Assured cannot be confirmed upon examination or ascertain at this moment, would you recommend to review his/her condition in the near future?  
YES / NO*  
If Yes, what is the appropriate time period for the Company to re-assess this claim?  
Day Month Year  

8. Please provide us with any other additional information that will enable the Company to assess this claim. Enclose copies of laboratory test results.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Date  ____________________________  Signature & Official Stamp of Doctor  ____________________________

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Claims Department  
1 Pickering Street #13-01  
Great Eastern Centre  
Singapore 048659  
Tel. 1800-248 2888 (Local), (65) 6248 2888 (Overseas)  
Email: claims-sg@greateasternlife.com  
Website: greateasternlife.com  
Jun 2014