ACCIDENT CLAIM FORM

Dear Claimant,

We are sorry to learn of your accident.

In order for us to process your claim, we require the following:

1) Claimant's Statement.
2) 1 Clinical Abstract Application Form.
3) Doctor's Statement (refer to Note I & II below).
4) **Original** medical bills/receipts.
5) **Original Final** Hospital Bills (if there's any hospitalisation) (refer to Note III below).
6) Police Report (if claim is due to a road traffic accident) (refer to Note III below).
7) Medical Certificates (refer to Note III & IV below).

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 toll-free line **1800-248-2888** or E-mail us at **Claims@Lifeisgreat.com.sg**.

Note:

I) For claims more than $1,000, the Doctor's Statement must be completed by the attending doctor and submitted to us. The Doctor's Statement is furnished at the expense of the claimant.

II) For claims less than $1,000, the Company may waive the medical report if there is sufficient documentary evidence to show the cause of hospitalisation/disability and period of disability. For example, Doctor's Memo certifying the date of accident, the injuries sustained and diagnosis.

III) For the documents mentioned in item (5) above, copies of the hospital bills will be accepted for Hospitalisation Allowance/Benefit claim. For the documents mentioned in items (6) & (7) above, copies are acceptable.

IV) The Medical Certificate must be issued by any physician qualified by degree in Western medicine and legally licensed and duly qualified to practise medicine and surgery.

V) We will not pay the claim for temporary disability (total & partial disability) of less than 7 continuous days for all Comprehensive Accident Benefits (CAB) Rider as per policy contract.

VI) Please continue to pay the premiums to keep your Policy in force.

VII) Authorisation letter from the claimant has to be submitted if the case is not handled by the Servicing Life Planner/Representative.

VIII) The Company does not admit liability by the mere issue of the claim forms.

IX) "The Company" refers to The Great Eastern Life Assurance Company Limited And/Or The Overseas Assurance Corporation Limited.

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

Great Eastern

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.*

** Notes:-*
1. Claims Department will contact you when the cheque is ready.
2. Option is available only if there are no outstandng documents to be submitted. Cheque will be delivered to your GSM Box the next working day after 12pm following our call to you.
3. For agency offices at Nankin Row, please collect the cheque at Customer Service Reception Counter at Ground Floor, Great Eastern Centre.

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 00003W)*
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659 Tel: 1800-248 2888 Fax: 6532 4406
Email: Claims@lifeisgreat.com.sg Website: www.lifeisgreat.com.sg

CLINICAL ABSTRACT APPLICATION

Important Note:

(i) This form is required for the application of medical report from hospital/clinic and should be completed by the patient or the patient's parent (if patient is below 21 years of age) or the patient's next-of-kin (if patient is deceased).

(ii) For request of medical report from hospital, this form is to be submitted to the Medical Records Department of the hospital.

*** Please delete accordingly**

To (Name of Doctor & Hospital/Clinic)

Date : _____

_____

_____

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. This report is required for an insurance claim. I confirm that a photocopy of the signed original 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 : _____

_____ _____

The Great Eastern Life Assurance Company Limited *(Reg. No. 1908 00011G)*
The Overseas Assurance Corporation Limited *(Reg. No. 1920 00003W)*
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659 Tel: 1800-248 2888 Fax: 6532 4406
Email: Claims@lifeisgreat.com.sg Website: www.lifeisgreat.com.sg

ACCIDENT/ GOLDEN PROTECTOR CLAIM
CLAIMANT'S STATEMENT

Great Eastern

Important Note:
(1) The Great Eastern Life Assurance Company Limited And/ Or The Overseas Assurance Corporation Limited hereby referred to as "The Company".
(2) The Doctor's Statement must be furnished (at the expense of the Policyholder) if the claim amount exceeds S$1,000.
(3) To be completed by the Policyholder.

* Please delete where appropriate

1 POLICY (IES) ISSUED BY THIS COMPANY

☐ Great Eastern Life Policy No(s).:

☐ Overseas Assurance Corporation Policy No(s).:

2 DETAILS OF POLICYHOLDER

Title: Mr/ Mrs/ Madam/ Ms/ Miss/ Dr

Name (According to NRIC/ Passport):

Residential Address:

Postal Code:

NRIC No:

E-mail Address:

Occupation:

Home Tel:

Office Tel:

HP/ Pgr No:

Claims Update via SMS : YES/ NO* *(Kindly note that this SMS facility is available for Great Eastern Life policies only).*

3 DIRECT CREDITING OF STAND-ALONE ACCIDENT & HEALTH (A&H) CLAIMS (Excludes A&H Rider Claims)

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

Important Notes: -
Direct Crediting will only be applicable for claims (excluding reimbursement to CPF Board) up to S$10,000 to a local bank account. Claim amounts will only be direct credited to the Policyholder's bank account. A cheque will be issued if claim is above S$10,000.

The Company will continue to credit all future/ further claim benefits payable to the above bank account, unless otherwise notified by the Policyholder.

4 DETAILS OF LIFE ASSURED (if different from (2))

Title: Mr/ Mrs/ Madam/ Ms/ Miss/ Dr

Name (According to NRIC/ Passport):

Residential Address:

Postal Code:

NRIC No:

E-mail Address:

Home Tel:

Office Tel:

HP/ Pgr No:

Date

Signature of Policyholder

The Great Eastern Life Assurance Company Limited *(Reg. No. 1908 00011G)*
The Overseas Assurance Corporation Limited *(Reg. No. 1920 00003W)*
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659 Tel: 1800-248 2888 Fax: 6532 4406
Email: Claims@lifeisgreat.com.sg Website: www.lifeisgreat.com.sg

5 DETAILS OF LIFE ASSURED'S OCCUPATION

Occupation: _____

Name of Employer: _____

Address of Employer: _____ Postal Code: _____

Description of Duties: _____

_____

6 DETAILS OF ACCIDENT AND MEDICAL TREATMENT

(a) Date of Accident: Day | Month | Year

(b) Time of Accident: _____

(c) Place of Accident: _____

(d) Detailed description of the Accident: _____

_____

_____

_____

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

If "YES", please state blood alcohol content/ drug type and quality consumed: _____

(f) Detailed description of the injuries: _____

_____

_____

(g) Name(s) and Telephone no(s) of witness(es):

Name of Witness	Telephone No.

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

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

_____

_____

(Please enclose a copy of the police report.)

_____ Date

_____ Signature of Policyholder

Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659 Tel: 1800-248 2888 Fax: 6532 4406
Email: Claims@lifeisgreat.com.sg Website: www.lifeisgreat.com.sg

CCLM

(i) Name and Address of Doctor who first attended to the Life Assured after the accident.

_____

_____

(j) Date when the Doctor first attended to the Life Assured. Day | Month | Year

(k) Name and Address of current Doctor, if different from above.

_____

(l) Was the accident reported to the Life Assured's employer? YES / NO*

7 DETAILS OF DISABILITY (FOR ACCIDENT CLAIM)

(a) Is the Life Asssured now or has the Life Assured been totally disabled from performing the duties of his/ her own or any other occupation? YES / NO*

(i) If "YES", state period of total disability: From: Day | Month | Year To: Day | Month | Year

(ii) Were the Medical Certificates for the above stated period submitted to the Life Assured's employer? YES / NO*

(iii) Did the Life Assured return to work during the above stated period? YES / NO*

If "YES", what are the exact duties that the Life Assured is unable to perform because of his/ her disability?

_____

_____

(b) Is the Life Assured now or has the Life Assured been partially disabled to perform only part or some of the duties of his/ her own occupation? YES / NO*

(i) If "YES", state period of partial disability: From: Day | Month | Year To: Day | Month | Year

(ii) Were the Medical Certificates for the above stated period submitted to his/ her employer? YES / NO*

(iii) Did the Life Assured return to work during the above stated period? YES / NO*

If "YES", what are the exact duties that the Life Assured is unable to perform because of his/ her disability?

_____

_____

_____ Date

_____ Signature of Policyholder

8 OTHER INSURANCE

Is the Life Assured claiming from any other sources (e.g. employer, other insurance companies, Workmen's Compensation) in respect of this Accident? YES / NO*

If "YES", please provide the following information.

Name of Employer/ Insurer	Date of Issue	Type of Plan	Claim Amount	Claim Notified (YES/ NO)	Claim Paid (YES/ NO)

DECLARATION

I declare that the answers given by me in this Form are in every respect true and correct and that no material information has been withheld nor any relevant circumstances omitted. I agree to the Company seeking information in connection with this claim from any source and I authorise the giving of such information. By filling the details of my bank account in Section 3 above, I authorise the Company to credit any claim proceeds of not more than S$10,000 into my designated bank account. A photocopy of this authorisation is as valid as the original.

_____

Signature of Policyholder

Name: _____

NRIC/ Passport No: _____

Date: _____

ACCIDENT CLAIM
DOCTOR'S STATEMENT

Great Eastern

Important Note: The below named is insured with The Great Eastern Life Assurance Co. Ltd And/ Or The Overseas Assurance Corporation Limited against the happening of certain contingent events associated with his/ her health. A claim has been submitted and to enable us to assess the claim, we would be obliged if you would complete this Doctor's Statement. The fees for the completion of this form shall be paid by the claimant.

* Please delete where appropriate

Name of Life Assured:

NRIC/ Passport No.:

1. Date of Accident: Day | Month | Year

Date of first consultation for this current condition: Day | Month | Year

Date(s) of subsequent consultation(s): _____

If the Life Assured had consulted another doctor before consulting you, please give name and address of that doctor.

_____

_____

2. (a) Detailed description of the injuries.

_____

_____

(b) Please state the diagnosis:

_____

_____

(c) Detailed description of the accident.

_____

_____

_____

(d) Were the injuries the result of the accident described above? YES / NO*

(e) (i) Were there any underlying illnesses/ conditions that attributed to the accident? YES / NO*

If "YES", please provide full details of condition (including the type of condition, the date of onset, the extent of physical/ mental infirmity) and describe how it attributed to the accident.

_____

_____

(ii) What was the proximate cause of the injuries/ disabilities?

_____

_____ _____

Date Signature of Doctor

The Great Eastern Life Assurance Company Limited *(Reg. No. 1908 00011G)*
The Overseas Assurance Corporation Limited *(Reg. No. 1920 00003W)*
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659 Tel: 1800-248 2888 Fax: 6532 4406
Email: Claims@lifeisgreat.com.sg Website: www.lifeisgreat.com.sg

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

If "YES", please state blood alcohol content/ drug type and quality consumed: _____

(g) Did the injuries result from a self-inflicted act? YES / NO*
If "YES", please give full description.

_____

_____

(h) Was a police report made in respect of the accident? YES / NO*
If "YES", please provide the name of the police division and police officer-in-charge's name.

_____

(Please enclose a copy of the police report.)

3. (a) What is the Life Assured's occupation and nature of work?

_____

_____

(b) Please state the period of Total Disability

(i) Period of *Total Disability: From: Day Month Year To: Day Month Year
*Total Disability refers to disability which prevents the Life Assured from performing each and every duty of his occupation.

(ii) Were medical certificates issued for the above stated period? YES / NO*
If "NO", please provide reasons: _____

_____

(iii) How and to what extent does the Life Assured's total disability prevent him/ her from performing all duties of his/ her occupation as stated above?

_____

_____

(iv) If the Life Assured is still totally disabled, how long is the total disability expected to last?

_____

(c) Please state the period of Partial Disability

(i) Period of **Partial Disability: From: Day Month Year To: Day Month Year
**Partially Disability refers to disability which prevent the Life Assured from performing one or more duty of his occupation.

_____ _____

Date Signature of Doctor

Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659 Tel: 1800-248 2888 Fax: 6532 4406
Email: Claims@lifeisgreat.com.sg Website: www.lifeisgreat.com.sg

CCLM

(ii) Were medical certificates issued for the above stated period? YES / NO*

If "NO", please provide reasons: _____

_____

(iii) What are some of the duties and to what extent of the Life Assured's occupation that he/ she is unable to perform as a result of his/ her partial disabilities?

_____

_____

(iv) If the Life Assured is still partially disabled, how long is the partial disability expected to last?

_____

(d) If Life Assured had been hospitalised or had undergone surgery, please state:

(i) Date admitted: Day | Month | Year

(ii) Date discharged: Day | Month | Year

(iii) Name of Hospital: _____

(iv) Nature of Surgical Procedure: _____

_____

(v) Date of Surgical Procedure: Day | Month | Year

(vi) Is further surgery likely to be required? YES / NO*

If "YES", please specify tentative date of surgery: Day | Month | Year

4. (a) Was the Life Assured suffering from any illness/ infirmity which was likely to protract the period of disability? YES / NO*

If "YES", please give details:

(i) Date of first diagnosis: Day | Month | Year

(ii) Diagnosis: _____

(iii) Name and address of doctor who made diagnosis:

_____

(iv) How it protracts the period of disability:

_____

_____

(b) What would be the usual recovery time if the Life Assured did not have the illness/ infirmity?

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor

5. Has the Life Assured been admitted to any hospital before, either for the same or different cause? YES / NO*
If "YES", please state.

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) of Attending Doctor(s)

6. Please provide us with any other additional information that will enable the Company to assess this claim.

_____

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor