Important Note: Please note that, under the policy terms and conditions, the policy may be void if any information provided in this claim form are made knowingly by you that is materially false or misleading.

Great Eastern
A member of the OCBC Group

CLAIM FORM - GREAT VALUE PROTECT

PART I - STATEMENT BY INSURED MEMBER

Name of Insured Member:

Policy No. : G

Policy Commencement Date :

Day | Month | Year

NRIC/PP/FIN NO:

Email address:

Contact no:

PART II - STATEMENT BY CLAIMANT:

Name of Patient :

*Relationship to Insured Member: ☐ Self ☐ Spouse ☐ Child

Date of Hospitalisation: Day | Month | Year

NRIC/PP/BC/FIN No:

Date of birth: Day | Month | Year

*Sex: ☐ M ☐ F

PART III - ACCIDENT DETAILS (COMPULSORY FOR CLAIM DUE TO ACCIDENT):

a. Date & Time of Accident

b. Place of Accident

c. Brief description of Accident

d. Brief description of Injuries

f. Is the accident work-related? ☐ Yes ☐ No

g. Are you making a claim from other insurance companies? ☐ Yes ☐ No

If YES, please state the name of insurance company and the policy number:

(please provide a copy of the other insurance company's claim settlement letter)

PART IV - DOCUMENTS TO BE SUBMITTED:

Please note claim may be rejected if incomplete supporting documents are provided** :

* Claim Event ☐ Accident ☐ Food Poisoning ☐ Dengue/Yellow Fever/Zika ☐ Covid-19

☐ A copy of Certificate of Insurance (COI)

☐ A copy of hospital discharge summary (for Hospital Allowance Claim)

☐ Original final summary hospital invoices (for Hospital Allowance Claim)

☐ Original invoices/receipts (for Medical Expenses Due to Accident Claim)

*** The Company reserved the right to request for further medical reports/information after assessing the claim documents submitted. The policyholder must bear the fee charged for the additional medical reports/information.*

Declaration and Authorisation

I declare that the statements and answers given above are true and complete and that I have not made any false or fraudulent statement or suppressed or withheld any material facts

I authorise any hospital, medical practitioner, clinic or any other person who has medically attended to or examined me or my eligible dependent to disclose to The Great Eastern Life Assurance Company Limited all medical records or information with respect to any illness or injury, medical history, consultations, prescription or treatment and copies of all hospital records.

A photostat copy of this authorisation shall be considered as effective and valid as the original.

By providing the information set out above, I agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") 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 evaluate, admit, process and/or settle my claims.

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

Date :

Signature of Insured Member/ Parent / Guardian (for Insured Member below 16 years old) :

* *please tick in the appropriate boxes.*