**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.



### **GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM**

#### **CLAIM SUBMISSION PROCEDURES**

Please read carefully before you complete the attached Claim Form.

- 1. The Great Eastern Life Assurance Company Limited (The Company) does not admit liability by the mere issue of this Form.
- 2. Please complete and answer all questions in full and tick in 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 both the original final itemised bills and summarized bills including the receipts. Photocopies of bills/receipts are NOT acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.

#### **ON ADMISSION TO HOSPITAL:**

1. On admission, the Patient or his/her family member must sign the **Medisave Authorisation** form (if the Patient's expenses can be paid for out of a Medisave Account), and pay a **deposit** (if any) as required by the hospital.

#### ON DISCHARGE FROM HOSPITAL

- 2. On discharge, Employer & Patient must complete Parts I & II of the Claim Form respectively and attach these documents:
  - The original hospital final bills, outpatient bills, outpatient bills/receipts, and follow-up bills for expenses incurred within 90 days
    of discharge.
  - b. Referral letter from a General Practitioner for any Pre-hospitalisation / Pre-Surgery Specialist Consultation.
  - c. A photocopy of the Hospital Admission Summary (if any).
  - d. Documents described below\*\*, depending on whether the Patient was admitted into a Government/Restructured Hospital or a Private Hospital.

#### \*\* Government / Restructured Hospital:

- e. Discharge Summary form from the hospital. This is provided free of charge to the Patient. The Patient must bear the fee charged should The Company obtained on behalf of the Patient.
- f. Clinical Abstract Application, duly completed by the Patient (or Parent/Guardian or Next-of-Kin).

#### \*\* Private Hospital:

- g. Patient must request the Attending Doctor/Surgeon to complete Medical Certification of Treatment Part III of this Claim Form and attach it to the other claim submission documents. The Patient must bear the fee charged for the completion of this medical report. The Company will not reimburse any part of this fee.
- h. Clinical Abstract Application, duly completed by the Patient (or Parent/Guardian or Next-of-Kin).

#### **CLAIM DISCHARGE**

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

Page 1/4

Tel 6248 2888 Fax 6532 3478 Website: greateasternlife.com



ART I - STATEMENT BY INSUI															
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bate:

\* please tick in the appropriate boxes.



## GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM

Singapore Government/

**Restructured Hospital** 

PART III- MEDICAL CERTIFICATION OF TREATMENT (TO BE FULLY COMPLETED BY ATTENDING DOCTOR/SURGEON)
--

Patient's behalf and bear up to a maximum of S\$75/- of the fee charged for it.

Please DO NOT arrange for this form to be completed. If required, Great Eastern Life will apply on the

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The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)



FOR OFFICIAL USE ONLY

Claim No:

# GROUP HOSPITAL AND SURGICAL INSURANCE CLAIM FORM CLINICAL ABSTRACT APPLICATION

				PID No.:
Form completed by the (please tick one box)	P	atient (if aged 21 arent or Guardiar lext of Kin (if Pation to Patient (if Nex	n (if Patient is a	a minor)
Group Policy No.				1
Name of Patient				
NRIC / PP / BC No.				
Period of Hospitalisation				to
as effective and valid a	-	/ Clinic * Numbe	r was	
		٦	Г	
Signature of *Patient or G	uardian / Parent	or Next of Kin	L	Signature of <b>Witness</b>
NameBLOO	CK LETTERS		Name	BLOCK LETTERS
Address			Address	
Date :			Date :	

<sup>\*</sup> Delete as necessary