

GROUP OUTPATIENT CLAIM FORM

CLAIM SUBMISSION PROCEDURES

Please read carefully before you complete the attached Claim Form.

The Great Eastern Life Assurance Company Limited (The Company) does not admit liability by the

- 1. 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. This Claim Form must be supported with the following documents: -
 - (i) All Final and Original itemised Bills or Receipts.

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

GROUP OUTPATIENT CLAIM FORM



Please read carefully before you complete the attached Claim Form.

- (i) Please complete and answer all questions in full and submit this form together with all final original and itemised bills and receipts not later than 30 days after the incurred date.
- (ii) The Great Eastern Life Assurance Company Limited (The Company) does not admit liability by the mere issue of this form.

PART I - EMPLOYEE DETAILS				
Name of Employer :(Policyhol	der):		Group Policy No. :	
Name of Employee(Insured M	ember) :		NRIC/PP No.:	
Employee's Email Address:			Employee's Contact No.:	
PART II - CLAIM DETAILS	Note: Please	submit Tax Invoice (showing breakd	own of the hill) rather than re	coint
Type of Claim (Please tick the a			own or the billy rather than re-	ocipt.
		ore Hospital (Please indicate time	of visit: a.m./p.r	n.)
		ease indicate time of visit:	-	•
Visit to Outpatient Cl	•		. ,	
<u> </u>	ialist / Outpatient D	iagnostic X-ray or Lab Test (Pleas	e attach a copy of the refer	rring letter
Others Please Spe	ecify			_
Name of Patient	*EE/ S/ C Dat	e of Consultation	Nature of Sickness/Diagnosis	Amount Incurred (S\$)
				(Οψ)
* EE denotes Employee / S de Please provide bank details Name of Bank		denotes Child ng of claims proceed via GIRO. Bank Account Num	ber Account Holder's	s Name
b. The Company will not be h into the bank account showc. The Company will continue	eld liable for any damage n above.	ok account as the Company will not allow creces, costs, losses or expenses as a result of the creating benefits to the above Bank Account, or	ne claims proceed being credited	
Policyholder/Employee. d. Please note the GIRO payr e. The amount payable via G	* *	counts in Singapore only. 00.00. Any payment amount above S\$10,000.	00 will be made by cheque	
		true and complete to the best of my knowled	<u> </u>	
 I hereby authorised any home my eligible dependent to di medical history, consultation 	spital, medical practition sclose to Great Eastern ons, prescription or treat	Life all medical records or information with re clife all medical records or information with re ment and copies of all hospital records. idered as effective and valid as the original.	lly attended to or examined me or	
	pany will not be held liab	ele for any damages, costs, losses or expense	es as a result of the claims proceed	
respective representatives such personal data to the evaluate, admit, process	and agents ("Represen Companies' authorised and/or settle my clai	e and consent to Great Eastern, its related of tatives") collecting, using, disclosing and she di service providers and relevant third partie ms. These purposes are set out in Gre discourity-policy.html and which I confirm I ha	aring amongst themselves my persons ses for purposes reasonably require at Eastern's Privacy Statement,	onal data, and disclosed by the Companies
Signature of Insured Membe	er:		Date:	
Authorised Signatory & Date	: :	Name of Authorised Signatory:	Company's Stamp:	