

**GROUP PERSONAL ACCIDENT 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. This Claim Form must be supported with the following documents :-
  - (i) Claimant's Statement.
  - (ii) Clinical Abstract Application Form.
  - (iii) Doctor's Statement (refer to note 2 below).
  - (iv) All available Laboratory and Test Results.
  - (v) Copy of Birth Certificate / Identity Card / Passport of the Insured Member (certified to be a true copy by an authorised senior officer of the Policyholder).
  - (vi) Copy of Insured Member's latest payslip (certified to be a true copy by an authorised senior officer of the Policyholder).
  - (vii) Copy of Police Statement if the accident was reported to the Police (certified to be a true copy by an authorised senior officer of the Policyholder).

- Notes:**
1. The Company reserves the right to call for any original documents.
  2. Insured Member must request the **Attending Doctor/Surgeon** to complete the **Doctor's Statement** of this **Claim Form** and attach it to the other claim submission documents. **The Insured Member must bear the fee charged** for the completion of this medical report. **The Company will not reimburse any part of this fee.**

**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 PERSONAL ACCIDENT CLAIM  
INSURED MEMBER'S STATEMENT**

**Important Note :** (a) The Great Eastern Life Assurance Company Limited is hereby referred to as "the Company".  
 (b) The Company does not admit liability by the mere issue of this or any other form.  
 (c) This form must be completed by the Policyholder and signed by an authorised representative.

**1 STATEMENT BY POLICYHOLDER (EMPLOYER)**

Name of Employer :

Policy No :  Please pay benefits to  Employer  Employee

Name of Employee :

NRIC/ Passport No :  Date of Birth :    Sex  Male  Female

Occupation :

Sum Insured :  Employment Date :    Date Last Actively At Work :

Average Salary For the Last 12 Months :  Date Salary Was Last Adjusted :

**2 DECLARATION BY POLICYHOLDER (EMPLOYER)**

We, the Policyholder, declare that the information given in this statement is true and complete and have not withheld any material fact to the best of our knowledge and belief. We agree that the furnishing of this form, or any other supplemental forms, by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the Insured Member in question nor a waiver of any of its rights or defences.

We hereby confirm and represent to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") that each insured member of the policy ("Insured Members"), under which we are submitting our claims, has agreed and consented to the disclosure of their personal data to the Companies and their Representatives, and further, that for the Companies and their Representatives' collection, use and/or disclosure of the personal data of the Insured Members, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonable required by the Companies to evaluate, admit, process and/or settle our claims. In respect of the Insured Members who are subsequently enrolled into the policy, under which we are submitting our claims, we further undertake that we shall ensure and procure that each of such Insured Members has provided such agreement and consent in relation to his/her personal data for such purposes.

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

Authorised Signatory & Date :	Name of Authorised Signatory :	Company's Stamp :

**3 STATEMENT BY INSURED MEMBER (EMPLOYEE)**

Name of Insured Member :

NRIC/ Passport No :  Date of Birth :    Sex  Male  Female

**4 DETAILS OF ACCIDENT**

(a) Date & Time of Accident:         :    AM  PM

(b) Place of Accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(c) Describe in detail how the Accident happened.

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(d) Describe the Insured Member's injuries.

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(e) Were there any eye witnesses to the accident? Yes  No   
If "YES", give name(s) and address(es) of witness(es).

Name of witness	Address

(f) 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 & contact number.

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(Enclose a copy of the police report.)

(g) Name and Address of Doctor who first attended to the Insured Member after the accident.

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(h) Date when the Doctor first attended to the Insured Member.

Day	Month	Year

(i) Name and Address of Doctor now in attendance, if not the same as above.

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**5 RECORD OF MEDICAL CONSULTATIONS**

(a) Provide the details of any doctors who have been consulted in connection with the Insured Member's illness:

Name(s) of Doctor	Name(s) of Clinic(s) / Hospital(s) and Address	Date(s) of First Consultation

(b) Provide the name(s) and address(es) of the Insured Member's regular doctor(s).

Name(s) of Doctor	Name(s) of Clinic(s) / Hospital(s) and Address	Tel No.(s)

**6 PERIOD OF MEDICAL LEAVE - TO BE SUPPORTED BY MEDICAL LEAVE CERTIFICATE (DD/MM/YY)**

Full Medical Leave		Light Duties Medical Leave	
From (Day/Month/Year)	To (Day/Month/Year)	From (Day/Month/Year)	To (Day/Month/Year)
1			
2			
3			
4			
5			

(a) Is the Insured Member still confined to House / Hospital? Yes  No

## 7 OTHER INSURANCES

Is the Insured Member claiming from any other insurance company or other sources in respect of this illness?

Yes  No

If "YES", provide the following information.

Name of Insurer	Date of Issue	Sum Insured	Type of Plan	Claim Amount	Claim Notified	
					YES	NO
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

## 8 DECLARATION BY INSURED MEMBER (EMPLOYEE)

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. A photocopy of this authorisation is as 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.greasternlife.com/sg/en/privacy-and-security-policy.html> and which I confirm I have read and understood.

\_\_\_\_\_  
Signature of Insured Member

\_\_\_\_\_  
Name of Insured Member

**GROUP PERSONAL ACCIDENT CLAIM FORM**

**FOR OFFICIAL USE ONLY**

**CLINICAL ABSTRACT APPLICATION**

Claim No :

PID No.:

- Form completed by the (please tick one box)
- Patient (if aged 21 years and above)
  - Parent or Guardian (if Patient is a minor)
  - Next of Kin (if Patient is deceased) \*\*

\*\* Relationship to Patient (if Next of Kin) : \_\_\_\_\_

Group Policy No.	
Name of Patient	
NRIC / PP / BC No.	
Period of Hospitalisation	_____ to _____

**I hereby authorise** any hospital, physician, or other person who has attended to or examined \* me / my child / the above Patient, or is authorised to maintain the Patient's medical records, **to disclose to** (or when requested to do so by) The **Great Eastern Life** Assurance Company Limited **any and** all information with respect to any illness or injury, medical history, consultations, prescriptions or treatment of the Patient. A photostat copy of this authorisation shall be considered as effective and valid as the original.

**Patient's Admission / E Unit / Outpatient / Clinic \* Number** was

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of \*Patient or Guardian / Parent or Next of Kin

Signature of **Witness**

Name : \_\_\_\_\_  
BLOCK LETTERS

Name : \_\_\_\_\_  
BLOCK LETTERS

Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date : \_\_\_\_\_

Date : \_\_\_\_\_

\* **Delete as necessary**



(c) If further recovery is expected please give details below.

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(d) Describe in detail how the accident happened.

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(e) Were the injuries the result of the accident described above? Yes  No

(f) Was the Insured Member under the influence of alcohol at the time of the accident? Yes  No

If "YES", please state blood alcohol content: \_\_\_\_\_

(g) Did the injuries result from a self-inflicted act? Yes  No

If "YES", please give full description.

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

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(b) Please state the period of Total Disability

(i) Period of \*Total Disability: From

Day	Month	Year

To

Day	Month	Year

(ii) Were medical certificates issued for the above stated period? Yes  No

If "NO", please provide reasons.

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

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(c) Please state the period of Partial Disability:

(i) Period of \*\*Partial Disability: From

Day		Month		Year	

To

Day		Month		Year	

(ii) Were medical certificates issued for the above stated period?

Yes  No

If "NO", please provide reasons.

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

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Note: \* Total Disability refers to disability which prevents the patient from performing each and every duty of his occupation.

\*\*Partial Disability refers to disability which prevents the patient from performing one or more duties of his occupation.

(d) If the Insured Member is still totally disabled, how long is the total disability expected to last?

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(e) If the Insured Member is still partially disabled, how long is the partial disability expected to last?

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(f) If Insured Member 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.

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(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 Insured Member suffering from any illness / infirmity which was likely to protract the period of disability?

Yes  No

If "YES", please give details like date of diagnosis , diagnosis made, name & address of doctor who made the diagnosis and how it protracts the period of disability.

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(b) Please also comment the usual recovery time of the injuries if the Insured Member did not have these other illness.

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5. Has the Insured Member 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.

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Signature of Doctor/Surgeon

Date :

Day	Month	Year

Name, Address and Qualification of Doctor/Surgeon  
(To affix Doctor's Stamp)