SCHOOL STUDENT'S ACCIDENT PROTECTOR 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 accident.

4. Please submit only **original final itemised bills** (not summarized bills) and receipts. Photocopies of bills/receipts are **NOT** acceptable. Please keep details/copies for your own records as bills/receipts will not be returned.

5. Please submit all claim documents through your Life Planner or your School.

6. This Claim Form must be supported with the following documents :-

   (i) Claimant's Statement :
   - To be fully completed and signed by Parent/Legal Guardian of the Insured Member (the Insured Student) and the Policyholder (School) if claimant is a student, or
   - To be fully completed and signed by the Patient and the Policyholder (School) if claimant is a Teacher or Non-Teaching Staff.

   (ii) Medical Examiner's Certificate :

   (iii) Original Final Itemised Bills and Receipts

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 **Medical Examiner's Certificate** of this **Claim Form** and attach it to the other claim submission documents, **if the claim amount exceeds S$500.00. 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.

Great Eastern
A member of the OCBC Group

SCHOOL STUDENTS' ACCIDENT PROTECTOR (SPA) CLAIM FORM

PART I - STATEMENT BY POLICYHOLDER (SCHOOL)

Name of School (Policyholder):

Policy No. : G

Name of Student / Teacher / Non-Teaching Staff (Life Insured):

NRIC/PP No:

Date of Birth: Day Month Year

Sex : Male Female

*Please state to whom benefit payment should be made to:

- School (Policyholder)
- Parent/Legal Guardian
- Principal / Teacher / Non-Teaching Staff

Name of Principal / Teacher / Non-Teaching Staff :

*Claim payment should be forwarded to:

- Life Planner
- School Directly

Attention of :

Signature & Date of Principal/Teacher-in-charge:	Name of Principal/Teacher-in-charge:	School (Policyholder)'s Stamp:

PART II - STATEMENT BY LIFE INSURED (STUDENT / TEACHER / NON-TEACHING STAFF)

Name of Patient:

NRIC/PP/BC No:

Name of Parent / Legal Guardian (if claimant is a student):

Sex of Parent / Legal Guardian

- Male
- Female

NRIC/PP No of Parent / Legal Guardian (as above)

Date of Birth of Parents / Legal Guardian

Nationality (please tick)

- Singaporean
- Others, Please specify

Address (Residence), Including Postal Code:

Contact Number:

Relationship to Life insured (please circle): Parent / Legal Guardian

PART III - DESCRIPTION OF ACCIDENT

Place of Accident:

Date of Accident: Day Month Year

Brief description of Accident:

Nature and extent of Injuries sustained:

Name(s) / NIRC No(s) of Witness(es): (i)

(ii)

PART IV - OTHER INSURANCE(S)

Are you entittled to and have obtained compensation for medical expenses incurred for the treatment of the injury(ies) sustained described above from any other source [eg. Parents' employers, other insurances (including Medishield)]?

Yes ☐ No ☐

If "YES", please give the following details.

Name of Employer, Insurance Company, etc	Address	Telephone Number

PART V - DECLARATION BY LIFE INSURED

1 I DECLARE that the Life Insured received the above injuries solely and directly by violent, accident and visible means.

2 I WARRANT that the statements and facts are true and that I have not withheld from the Company any medical information in connection with this claim.

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/sg/en/privacy-and-security-policy.html and which I confirm I have read and understood.

Date:	Day		Month		Year			

Signature of Parent / Legal Guardian / Teacher / Non - Teaching Staff*

Name of Parent / Legal Guardian / Teacher / Non - Teaching Staff*

***To be completed by Parent or Legal Guardian of student if claimant is a student, or by claimant if claimant is a teacher or non-teaching staff.**

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PART VI - MEDICAL EXAMINER'S CERTIFICATE

Name of Patient (Insured Member):

NRIC/PP/BC No:

I HEREBY CERTIFY that I personally examined the Injuries suffered by the Insured Member in the Accident described under Part I of this Claim Form and that my records and medical opinion are as follows:

1 Date of Examination of Injuries — Day / Month / Year

2 (a) Please describe nature and severity of the injuries / disabilities.

(b) Are there any *permanent body defects* sustained by the Insured Member following the accident after the injuries has been stabilised with no improvement or deterioration is expected?

Yes ☐ No ☐

If "YES", please give full details of the extent of loss of use of the Affected Part or Site and the percentage of Permanent Incapacity.

3 (a) Were the Injuries consistent with the description of the Accident ? Yes ☐ No ☐

If "No", please give details.

4 (a) State as fully as possible the Treatment provided or Surgical Procedure(s) performed (if any).

(b) Date of Surgery performed (if any) — Day / Month / Year

5 (a) Were the Injuries sustained of such nature that the Insured Member required hospitalisation? Yes ☐ No ☐

If "YES", please give the following details:

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

Signature of Doctor/Surgeon

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

Date: Day / Month / Year

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

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