A Member of the OCBC Group

GROUP TERMINAL ILLNESS 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 Assured Member (certified to be a true copy by an authorised senior officer of the Policyholder).

   (vi) Copy of Assured Member's latest payslip (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. Assured 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 Assured 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 TERMINAL ILLNESS CLAIM
ASSURED MEMBER'S STATEMENT

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

1. STATEMENT BY POLICYHOLDER (EMPLOYER)

Name of Employer

Policy No G

Please pay benefits to ☐ Employer ☐ Employee

Name of Employee

NRIC/ Passport No

Date of Birth Day Month Year

Sex ☐ Male ☐ Female

Occupation

Sum Assured

Employment Date Day Month Year

Date Last Actively At Work Day Month Year

Average Salary For the Last 12 Months

Date Salary Was Last Adjusted Day Month Year

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 Assured 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 consent 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 we confirm each of us and the Insured Members have read and understood.

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

3. STATEMENT BY ASSURED MEMBER (EMPLOYEE)

Name of Assured Member

NRIC/ Passport No

Date of Birth Day Month Year

Sex ☐ Male ☐ Female

4. NATURE OF CLAIM AND RELATED DETAILS

(a) Describe fully the symptoms for which the Assured Member consulted a doctor.

(b) How long did the Assured Member have the symptoms before he/she consulted a doctor?

(c) Date when the Assured Member FIRST consulted a doctor:

Day		Month		Year			

(d) If consultation was for illness, describe fully the extent and nature of the Assured Member's illness.

(e) If consultation was due to an accident, describe fully the nature of the Assured Member's injuries and how it happened.

(f) Has the Assured Member previously suffered from or received treatment for a similar or related illness or injury? Yes ☐ No ☐

If "YES", please give full details.

5. RECORD OF MEDICAL CONSULTATIONS

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

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

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

Name(s)	Address(es)	Tel No.(s)

6. OTHER INSURANCES

Is the Assured Member claiming from any other insurance company or other sources in respect of his/her illness or injury?

Yes ☐ No ☐

If "YES", provide the following information.

Name of Insurer	Date of Issue	Sum Assured	Type of Plan	Claim Amount	Claim Notified YES	Claim Notified NO
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

7. DECLARATION BY ASSURED 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.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I confirm I have read and understood.

Date: Day Month Year

Signature of Assured Member

Name of Assured Member

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GROUP TERMINAL ILLNESS CLAIM FORM

CLINICAL ABSTRACT APPLICATION

FOR OFFICIAL USE ONLY
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

Address : _____

Date : _____

Name : _____
BLOCK LETTERS

Address : _____

Date : _____

**** Delete as necessary***

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GROUP TERMINAL ILLNESS CLAIM
DOCTOR'S STATEMENT

Important Note: The Assured Member, named below, is insured with the Great Eastern Life Assurance Co. Ltd against the happening of certain contingent events associated with his/her health. A claim has been submitted and to enable us to access the claim, we will be obliged if you would complete this Doctor's Statement. The fees for the completion of this form shall be paid by the claimant.

Name of Assured Member: :

NRIC / Passport No. :

1. Are you the Assured Member's usual medical doctor? Yes ☐ No ☐

   If "YES", since what date? Day Month Year

2. (a) Date when Assured Member first consulted you for the condition resulting in Terminal Illness: Day Month Year

   (b) Please state the symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (Day/Month/Year)

   What is the source of this information? Patient ☐ Referring Doctor ☐ Others ☐

   If "Others", please specify: _____

   (c) Please provide full and exact details of the condition causing terminal illness, include dates.

   _____

   _____

   (d) Date when Assured Member first became aware of the illness/condition: Day Month Year

   (e) Date when Assured Member first became aware that the condition was terminal: Day Month Year

3. (a) Details of current symptoms and treatment.

(b) Has active therapy now been rejected in favour of relief of symptoms?

(c) Can you confirm that the advent of death is highly probable within 12 months?

4. (a) Has the Assured Member previously suffered from the condition specified above or any possible related illnesses?

Yes ☐ No ☐

If "YES", please give dates of consultations and the resulting diagnosis.

(b) Is there anything in the Assured Member's personal medical history which would have increased the risk of the condition resulting in terminal illness?

Yes ☐ No ☐

If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

(c) Is there anything in the Assured Member's family history which would have increased the risk of the terminal condition?

Yes ☐ No ☐

If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

(d) Please give details of the Assured Member's habits in relation to cigarette smoking, including the duration of smoking habits and source of information.

(e) Is the Assured Member suffering or has suffered from any other significant illnesses? Yes ☐ No ☐

If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

5. (a) Did the Assured Member consult other doctors for this illness or its symptoms before he/she consulted you?

Yes ☐ No ☐

If "YES", please give name(s) and address(es) of the doctor(s) whom he/she consulted.

Name of Doctor	Name of Clinic / Hospital and Address

(b) Please provide the names and addresses of any hospital or clinic to which the Assured Member was referred to and the names of the consultants attended.

6. Please state and attach copies of all hospital reports, laboratory and test results.

7. Please provide us with any other additional information that will enable the Company to assess this claim.

Signature of Doctor/Surgeon

Date :

Day		Month		Year			

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