

GROUP TOTAL & PERMANENT DISABILITY 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) Insured Member's Statement.
 - (ii) Clinical Abstract Application Form.
 - (iii) Doctor's Statement (refer to note 2 below).
 - (iv) 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).
 - (v) Copy of Insured Member's latest payslip prior to the commencement of disability (certified to be a true copy by an authorised senior officer of the Policyholder).
 - (vi) Copy of Tax Statement - IR8A form (certified to be a true copy by an authorised senior officer of the Policyholder).
 - (vii) Any police statement/newspaper report relating to Insured Member's disability if it is due to an accident.

- 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 cost for completion of this Doctor's Statement will have to be borne by the Insured Member / Policyholder.**
 3. Authorised Officer of the Policyholder must be stated and declared in MAS 314 Form.

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.

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

Mailing Address: 200 Changi Road #04-00 Singapore 419734

Tel 6248 2888 Fax 6532 3478 Website: greateasternlife.com

GROUP TOTAL & PERMANENT DISABILITY CLAIM INSURED MEMBER'S STATEMENT

- 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		<input type="checkbox"/> Employer			<input type="checkbox"/> Employee							
Name of Employee :																				
NRIC/Passport No :									Date of Birth	Day Month Year			Sex		<input type="checkbox"/> Male		<input type="checkbox"/> 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 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	Day Month Year			Sex		<input type="checkbox"/> Male		<input type="checkbox"/> Female		

4. DETAILS OF CURRENT DISABILITY

	Day	Month	Year
(a) Date of Disability			
(b) Describe fully the symptoms for which the Insured Member consulted a doctor.			

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

(d) Date when the Insured Member First consulted a doctor.

Day	Month	Year

(e) If the Insured Member's disability is due to sickness, give a full description of his/her illness.

(f) Has the Insured Member suffered from this disability before?
If "YES", give dates and details of doctors consulted.

Yes			No		
Day	Month	Year	Day	Month	Year

(g) If the Insured Member's disability resulted from accident:

(i) Describe how the accident occurred and injuries sustained.

(ii) State the date of accident:

Day	Month	Year

(h) State the date when the Insured Member's disability totally prevented him/her from performing his/her occupation:

Day	Month	Year

5. DETAILS OF DOCTOR(S) CONSULTED FOR PRESENT DISABILITY

(a) State the names and addresses of all doctors who treated the Insured Member for his/her present disability.

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

(b) If as a result of the Insured Member's disability, he/she has been:

(i) Hospitalised, please give:

Name(s) of Hospital(s)	Date(s) of Admission	Date(s) of Discharge

(ii) Confined to his/her home, please give the dates of confinement:

From:

Day	Month	Year

To:

Day	Month	Year

6. OTHER INSURANCES

Is the Insured 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	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"/>

12. 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."

Day	Month	Year

Date:

Signature of Insured Member

Name of Insured Member

**GROUP TOTAL AND PERMANENT DISABILITY CLAIM
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 _____
<p>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.</p>	
Patient's Admission / E Unit / Outpatient / Clinic * Number was	<input style="width: 150px; height: 20px;" type="text"/>

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

Signature of **Witness**

Name : _____
BLOCK LETTERS

Name : _____
BLOCK LETTERS

Address : _____

Date : _____

Address : _____

Date : _____

 * **Delete as necessary**

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

If "YES", what was the blood alcohol content? _____

(j) Is the disability due to pregnancy, self-inflicted or caused / aggravated by the taking of alcohol or unprescribed drugs? Yes No

If "YES", please state the cause.

(k) Current occupation before disability: _____

(l) Nature of duties of current occupation.

(m) How did the Insured Member's disability prevent him/her from performing the above listed duties of his/her occupation?

(n) Type of treatment/s including any operations performed and his/response to the treatment/s.

2. Insured Member's Condition

(a) Please describe fully the nature and severity of the Insured Member's disabilities.

(b) Is his / her disability progressive, stationary or improving?
Progressive Stationary Improving

(c) Is full recovery expected? Yes No

If "YES", please state approximate date:

Day	Month	Year

If "NO", please state the extent of recovery and approximate date.

Day	Month	Year

(d) Is the Insured Member able to perform all Activities of Daily Living (ADL) without assistance? Yes No

If "NO", please state which one(s) of the ADLs he / she is unable to perform independently.
The 6 ADLs include feeding, mobility, continence, bathing, dressing and toileting.

(e) Is the Insured Member confined to a home, hospital or other Institution that provides constant care and medical attention? Yes No

If "YES", since what date?

Day	Month	Year

(f) Does the Insured Member have full power of all limbs? Yes No

If "NO", please specify which limb(s) do(es) not have full power and the current power of limbs.

(g) Please give full details with respect to the Insured Member's mental abilities and cognition.

(h) Is the Insured Member able to perform all the normal duties of his/her occupation? Yes No

If "YES", when is he / she expected to return to his usual occupation?

Day	Month	Year

(i) If he / she is unable to return to his / her usual occupation, is he / she able to engage in any other occupation?

Yes No

If "YES",

(i) What types of occupation can he / she engage in?

(ii) When can he / she expect to engage in these occupations?

Day	Month	Year

3. MEDICAL HISTORY

(a) Did the Insured Member consult other doctors for this illness or it's 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) Is the Insured Member suffering or has suffered from any other significant illnesses?

Yes No

Illness	Date of First Diagnosis (D/M/Y)	Name and Address of Attending Doctor

(c) Are you the Insured Member's regular doctor?

Yes No

If "YES", since what date?

Day	Month	Year

If "NO", please state the name and address of the Insured Member's regular doctor.

(d) Is the disability total and permanent and result in the "complete inability of the Insured Member to engage in any gainful occupation, profession or employment for compensation, profit or gain for the remainder of his lifetime as a result of accidental bodily injury, sickness or disease; provided however that such disability shall have lasted for not less than six months duration." Yes No

If "YES" , when did such disability commence?

Day	Month	Year

Please provide us with any other additional information that will enable the Insurer to assess this claim. Please enclose copies of laboratory test results.

Signature of Doctor/Surgeon

Date :

Day	Month	Year

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