INTEGRATED SHIELD CLAIMS RECOVERY AUTHORISATION FORM

To: Health Claim Services Department
The Great Eastern Life Assurance Company Limited (**"Great Eastern"**)
1 Pickering Street #01-01
Great Eastern Centre
Singapore 048659

Name of Life Assured : _____
Policy Number :
Hospitalisation Period : to
(the "**Hospitalisation**")

In accordance with the terms of my Integrated Shield Plan, I/we would like to inform you that the Life Assured's Hospitalisation is also covered under insurance provided by another insurer and/or company. The details of this other insurance are as follows:-

The Other Insurer/Company : _____
(the "**Other Insurer & Company**")
Policy Number : _____

To enable Great Eastern to seek reimbursement from the Other Insurer/Company of all and any claims Great Eastern has paid out in respect of the Hospitalisation (**"Reimbursement"**), I/we authorise and agree to the following:-

1. Great Eastern can collect, use or disclose, as they reasonably consider appropriate, any information or

   (a) Great Eastern's claim settlement letters issued to me; and
   (b) Medical invoices issued by the Life Assured's medical provider.

2. The Other Insurer/Company (including its Human Resource personnel, where appropriate) can liaise with Great Eastern directly regarding the procedures and/or documentation required for the Reimbursement. I understand that I/we will still be required to sign-off on the relevant claim forms.

By filling in and sending this Authorisation Form to Great Eastern, I/we agree and consent to Great Eastern, its related corporations (collectively, the "**Companies**"), as well as their respective representatives, agents, the Companies' authorised service providers and relevant third parties, and the Other Insurer/Company, collecting, using and/or disclosing my/our personal data for purposes reasonably required by Great Eastern to seek Reimbursement.

A photocopy of this authorisation is as valid as the original.

_____ _____
Signature of Policyholder* Signature of Life Assured
(If different from Policyholder)

_____ _____
Name of Policyholder* Name of Life Assured

Date: _____ Date: _____
Contact Number: _____ Contact Number: _____
(*Policyholder can also be trustee/assignee.)

CCLM
CCLMCR