

DISABILITY INCOME / WAIVER OF PREMIUMS (DISABILITY) CLAIM / LONG TERM GOLDENCARE CLAIMANT'S STATEMENT



Important Note:

- 1 The Great Eastern Life Assurance Company is hereby referred to as "The Company".
 - 2 To be completed by the Policyholder. Date format in DD/MM/YYYY. Submit this together with supporting documents.
 - 3 All eligible policies will be processed together.
 - 4 Please ensure your contact details with the Company, including mobile no. and email address are updated to receive your correspondences.
- * Please tick where appropriate.

1 Details of Policyholder / Life Assured

Full Name:

NRIC / Passport No.(for foreigner only):

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Details of Life Assured (if different from Policyholder)

Full Name:

NRIC / Passport No.(for foreigner only):

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Highest Education Level:

Since the policy commencement, has the Life Assured resided or travelled abroad for a continuous period of 6 months or more?

Yes No If Yes, date of leaving Singapore

Date of return

2 Occupation Details

Note: If the Life Assured is not working before disability, provide a list of daily activities before and after the disability.

Before Disability

After Disability

a) Name of Employer:

b) Position:

c) Main duties:

d) Date first day of work:

e) Date last day of work:

f) Average monthly income in last 12 months (S\$):

g) Are you self-employed, or was an independent contractor or sole proprietor before disability? YES NO

h) Other source of income (Any benefit or remuneration the Life Assured is receiving or the Life Assured expects to receive because of his/ her disability from other insurance company or from any other source. (Attach documentary evidence)

Source	Amount	Date of Commencement of payment	Date of Termination of payment
	S\$ per		
	S\$ per		

3 Details of Disability

a) If the disability is due to Illness, please state details:

Date symptoms started: (DD/MM/YY)

Describe symptoms in full:

b) If the disability suffered is due to Accident, please state details:

Date of Accident: (DD/MM/YY)

Time: AM / PM

Place of Accident:

Details of the accident:

Details of the injuries:

Signature of Claimant

Date



c) State the date when the disability prevented you from performing your occupation: (DD/MM/YY)

How does the disability prevent you from performing the above duties?

4 Details of Medical Consultations

Details of consultation for this disability, similar disability in the past and other conditions:

Date of first treatment	Medical Condition/Disability	Name & Address of Doctor

Details of hospitalisation such as Date of Admission, Date of Discharge and Name of Hospital, if any.

YES NO

5 Other Insurance

YES NO

Date of Issue	Name of Insurer	Type of Plan	Sum Assured (S\$)	Claim Notified

6 Settlement Option

PayNow is the default settlement option up to S\$200,000 per policy:

To align with the nation's initiatives to go cheque-free, PayNow is the default settlement option up to S\$200,000 for policyholder who has registered with PayNow and has linked his/her Singapore NRIC to the bank account ("PayNow Account"). You hereby authorise and instruct The Company to deposit the payment that is payable to you into your PayNow Account as well as verify your PayNow Account with the respective Bank ("where necessary"). In the event that the PayNow transaction is unsuccessful, a cheque for the payment will be issued to you.

For payment more than S\$200,000 per policy, or PayNow transaction is not available / unsuccessful:

Cheque to be collected by myself at Customer Service Counter of Great Eastern Centre.

Cheque to be posted to me via my mailing address registered with The Company.

Telegraphic Fund Transfer

For Claimant residing overseas only. This is subject to The Company's approval and complete submission of requirements.

Cheque to be collected by The Company's Financial Representative.

Name:

Signature of Claimant

Date



Declaration

I hereby declare that to the best of my knowledge and belief, the information, answers and statements provided above are in every respect true, complete and correct, and that no material information has been withheld nor is any relevant circumstances omitted.

I hereby agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my/Life Assured's 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 process and administer 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, including without limitation:

- (a) the Companies, their representatives, agents, authorised service providers and other relevant third parties ("Requesting Parties") may collect medical information concerning me/Life Assured from any persons possessing the same (such as doctors whom I/Life Assured have consulted), and I hereby authorise those persons to release the same to any of the Requesting Parties for the purpose of my claims, and
- (b) the Requesting Parties may disclose any relevant information concerning me/Life Assured (including my/Life Assured's medical information) to other parties, which any of the Requesting Parties deems necessary for the purpose of my claims.

I further agree that this declaration shall form part of my proposed application for the relevant insurance benefits, and a copy of this form shall be treated as valid and binding as if it were the original.

Full name: _____

Signature of Policyholder: _____

NRIC/Passport no.: _____

Date (DD/MM/YYYY): _____

Email address: _____

To be completed by The Company's Financial Representative ("Rep")

If Claimant has authorised you to collect the cheque, please give details:

- ☐ Collect at Customer Service Counter of Great Eastern Centre
- ☐ Drop into my Mailbox No. _____ at PLQ / GE House / Nankin Row / Westgate*

Full name: _____

Signature of Rep: _____

Mobile no.: _____

Date (DD/MM/YYYY): _____

