

**DISABILITY INCOME / WAIVER OF PREMIUMS (DISABILITY) CLAIM /  
LONG TERM GOLDENCARE CLAIMANT'S STATEMENT - 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/yy**. Submit this together with relevant tests.
- 3 All eligible policies will be processed together.
- 4 \*Please delete or circle where appropriate.
- 5 Please ensure your contact details with the Company, including mobile no. and email address are updated to receive your correspondences.



**1 Details of Policyholder / Life Assured**

Full Name:

NRIC No. / Passport No. / FIN No.:

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Details of Life Assured (if different from Policyholder)

Full Name:

NRIC No. / Passport No. / FIN No.:

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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\*

Date left Singapore:

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Date of return to Singapore:

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**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 provide details:

Date symptoms started:

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Describe symptoms in full:

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Signature of Claimant

Date



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

Date and time of Accident: 

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 AM / PM

Place of Accident: \_\_\_\_\_  
\_\_\_\_\_

Details of the accident: \_\_\_\_\_  
\_\_\_\_\_

Details of the injuries: \_\_\_\_\_  
\_\_\_\_\_

(c) State the date when the disability prevented you from performing your occupation: 

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

\_\_\_\_\_  
\_\_\_\_\_

#### 4 Details of Medical Consultations

(a) 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 Consulted

(b) Details of hospitalisation such as Date of Admission, Date of Discharge and Name of Hospital, if any. YES / NO\*

\_\_\_\_\_  
\_\_\_\_\_

#### 5 Other Insurance

Does the Life Assured have any existing insurance policies with other financial institutions? YES / NO\*

If "YES", please provide details of all policies.

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

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date



## 6 Settlement Option

### ☒ PayNow is the (Default Settlement Option)

I confirm that I have registered with PayNow and I have linked my Singapore NRIC/FIN to my bank account ("PayNow Account") whereby I am the Legal and Beneficial Owner of the PayNow Account. I hereby authorise and instruct The Company to deposit the payment that is payable to me into my PayNow Account as well as to verify my PayNow Account with the respective Bank (where necessary). This is applicable to SGD denominated policies only.

### ☐ Direct Credit option (if you do not have a "PayNow Account")

By selecting this option, I confirm that I have provided a copy of my recently issued bank statement / passbook / e-statement showing your full name, ID / address, bank name, branch and account number (with transaction and other details blanked out) for verification purposes.

<b>Name of Bank Account Holder</b>	<b>Bank Account No.</b>
<b>Name of Bank</b>	<b>Name of Branch</b>

### ☐ Telegraphic Fund Transfer (For Claimant residing overseas only)

Subject to The Company's approval, we will advise on further document(s) required.

## 7 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.greatasteernlife.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: \_\_\_\_\_  
NRIC/Passport/FIN No.: \_\_\_\_\_  
Email address: \_\_\_\_\_

Signature of Policyholder: \_\_\_\_\_  
Date (dd/mm/yy): \_\_\_\_\_

