ACCIDENT / GOLDEN PROTECTOR CLAIM
CLAIMANT'S STATEMENT

Great Eastern
An OCBC Company

Important Note: (1) The Great Eastern Life Assurance Company Limited hereby referred to as "The Company".
(2) The Doctor's Statement must be furnished (at the expense of the Policyholder) if the claim amount exceeds S$1,500.
(3) To be completed by the Policyholder.

* Please delete where appropriate

1 POLICY(IES) ISSUED BY THIS COMPANY

Policy No(s).:

2 DETAILS OF POLICYHOLDER (Please complete in BLOCK letters)

Name (According to NRIC/ FIN No.:)

NRIC/ FIN No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

Occupation:

Home Tel: Office Tel: HP No.:

E-mail Address:

3 SETTLEMENT OPTION

PayNow is the Default settlement option

PayNow is the default settlement option for policyholder who has registered with PayNow and has linked his/ her Singapore NRIC/ valid FIN and with the same FIN number registered under the Great Eastern Policy, 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").

If you prefer to receive payment via direct credit, please indicate as follows:

☐ **Credit into my personal bank account.**

Name of Bank	Branch of Bank	Bank Account Number	Account Holder's Name

Important Notes: Claim amounts will only be direct credited to the Policyholder's bank account. Please provide a copy of your 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. Direct crediting will only be applicable for claims (excluding reimbursement to CPF Board) to a local bank account.

4 DETAILS OF LIFE ASSURED (if different from (2)) (Please complete in BLOCK letters)

Name (According to NRIC/ FIN No.:)

NRIC/ FIN No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

Home Tel: Office Tel: HP No.:

E-mail Address:

Date

Signature of Policyholder

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659
t 1800 248 2888 (Local), (65) 6248 2888 (Overseas)
w greateasternlife.com > Contact Us

5 DETAILS OF LIFE ASSURED'S OCCUPATION

Occupation: _____

Name of Employer: _____

Address of Employer: _____ Postal Code: _____

Description of Duties: _____

_____

6 DETAILS OF ACCIDENT AND MEDICAL TREATMENT

(a) Date of Accident: Day Month Year

(b) Time of Accident: _____

(c) Place of Accident: _____

(d) Detailed description of the Accident: _____

_____

_____

_____

(e) Was the Life Assured under the influence of alcohol / drugs at the time of the accident? * YES / NO

If "YES", please state blood alcohol content / drug type and quality consumed: _____

(f) Detailed description of the injuries: _____

_____

_____

(g) Name(s) and Telephone no(s) of witness(es):

Name of Witness	Telephone No.

_____ _____

Date Signature of Policyholder

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h) Was the accident reported to the police? YES / NO*

If "YES", please provide the name of the police division & police officer-in-charge's name.

(i) Name and Address of Doctor who first attended to the Life Assured after the accident.

(j) Date when the Doctor first attended to the Life Assured. Day Month Year

(k) Name and Address of current Doctor, if different from above.

(l) Was the accident reported to the Life Assured's employer? YES / NO*

7 DETAILS OF DISABILITY (FOR ACCIDENT CLAIM)

(a) Is the Life Asssured now or has the Life Assured been totally disabled from performing the duties of his/ her own or any other occupation? YES / NO*

(i) If "YES", state period of total disability: From: Day Month Year To: Day Month Year

(ii) Were the Medical Certificates for the above stated period submitted to the Life Assured's employer? YES / NO*

(iii) Did the Life Assured return to work during the above stated period? YES / NO*

If "YES", what are the exact duties that the Life Assured is unable to perform because of his/ her disability?

(b) Is the Life Assured now or has the Life Assured been partially disabled to perform only part or some of the duties of his/ her own occupation? YES / NO*

(i) If "YES", state period of partial disability: From: Day Month Year To: Day Month Year

(ii) Were the Medical Certificates for the above stated period submitted to his/ her employer? YES / NO*

Date

Signature of Policyholder

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(iii) Did the Life Assured return to work during the above stated period? YES / NO*

If "YES", what are the exact duties that the Life Assured is unable to perform because of his/ her disability?

_____

_____

8 OTHER INFORMATION

Has the Life Assured or the Claimant been bankrupt or insolvent or has executed any deed or transfer for the benefit of creditors since becoming interested in the policy?

YES / NO*

9 OTHER INSURANCE

Is the Life Assured claiming from any other sources (e.g. employer, other insurance companies, Workmen's Compensation) in respect of this Accident? YES / NO*

If "YES", please provide the following information.

Name of Employer/ Insurer	Date of Issue	Type of Plan	Claim Amount	Claim Notified (YES/ NO)	Claim Paid (YES/ NO)

DECLARATION

I hereby declare that 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 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.greateasternlife.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 from any persons possessing the same (such as doctors whom I 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 (including my 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. By providing the details of my bank account in Section 3 above, I hereby authorise Great Eastern to credit any claim proceeds into the aforesaid bank account.

_____

Signature of Policyholder

Name: _____

NRIC/ FIN No: _____

Date: _____

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