



**CLAIM FOR BENEFITS UNDER GROUP HOSPITAL & SURGICAL POLICY**

**LOSS OF/DUPLICATE HOSPITAL & OTHER MEDICAL BILLS**

**DECLARATION BY INSURED MEMBER**

(\*Important Note: Insured Member is to complete on behalf of claimant if claimant is the dependent of the Insured Member)

Policyholder :  
Policy No :  
Insured Member :  
Claimant :  
NRIC / Passport No :  
Hospitalization (if applicable) : Hospital :  
Date(s) :

Please fill in each *individual lost/duplicate bill* below:

No.	Date of Visit	Name of Clinic/Hospital	Tax Invoice/Case No.

This is to confirm that this declaration is personally completed by (*Parent of Insured member*) , NRIC/Passport No \_and is true and correct. The undersigned hereby, unreservedly authorize Great Eastern Life Assurance Company Ltd all rights to:-

- (i) verify and exchange information pertaining to the hospitalization/surgery/outpatient treatment of the Insured Member on the dates above and all medical treatment related to the hospitalization/surgery/outpatient treatment between Great Eastern Life and any third party as Great Eastern Life may deem appropriate,
- (ii) fully recover any sums of money paid plus any other added costs incurred (including cost of recovery and litigation as deemed necessary) from **me** for their part in settling a claim for reimbursement of expenses incurred for the hospitalization/surgery/outpatient treatment of the Insured Member if Great Eastern Life obtains evidence that these expenses has been reimbursed by any other party.

I hereby confirm that the above ORIGINAL FINAL bill(s) for my hospitalization/surgery/outpatient treatment is/are lost or has/have not been received and has not been used for the purpose of claiming for reimbursement of the expenses against any other party.

Date: \_\_\_\_\_ Signed : \_\_\_\_\_  
Insured Member

Name :