LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
CORONARY ARTERY BY-PASS SURGERY OR CORONARY ARTERY DISEASE

* Please delete where appropriate

For Official Use
G E L S –

Name of Life Assured:

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

1. Are you the Life Assured's usual medical doctor? YES / NO*

If "YES", since what date? Day Month Year

2. (a) Date when Life Assured first consulted you for Coronary Artery By-Pass Surgery: Day Month Year

(b) Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (D/M/Y)

What is the source of this information? Patient / Referring Doctor / Others*

If "Others", please specify: _____

(c) Please describe the full and exact diagnosis of the heart disease leading to surgery.

_____

_____

(d) Date when illness / condition was FIRST diagnosed: Day Month Year

(e) Diagnosis was first made by (name of doctor): _____

(f) Date when Life Assured first became aware of the illness: Day Month Year

_____ _____

Date Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

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3. (a) Please state the type of surgery (e.g coronary by-pass grafting, keyhole surgery, atherectomy, myocardia laser revascularization, enhanced external counter pulsation, etc) performed.

Type of Surgery	Date of Surgery
If an open-chest (open-heart) surgery was performed, please state the number and sites of grafts inserted: Number of Grafts: _____ Sites of Grafts: _____	

(b) In which hospital was surgery performed? (Please state name and address.)

_____

_____

(c) Who performed the surgery? (Please state name and address.)

_____

_____

(d) With regards to the Life Assured's coronary artery disease condition, please provide the following:

Coronary Arteries (e.g right coronary artery, left main stem, left anterior descending and left circumflex, but not their branches)	Degree (Percentage) of blockage

Please attach a copy of angiograpm report.

4. (a) Has the Life Assured previously suffered from any risk factors or related illnesses e.g hypertension, diabetes, angina or other cardiovascular disease? YES / NO*

If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Name of Doctor	Name of Clinic / Hospital and Address

_____ _____

Date Signature of Doctor

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(b) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*
If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Name of Doctor	Name of Clinic / Hospital and Address

(c) Is there anything in the Life Assured's personal medical history which would have increased the risk of coronary artery disease? YES / NO*
If "YES", please give full details including the date of diagnosis, name and address of attending doctor and source of information.

(d) Is there anything in the Life Assured's family medical history which would have increased the risk of coronary artery disease? YES / NO*
If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

(e) Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of information.

(f) Please give details of the Life Assured's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

Date

Signature of Doctor

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5. (a) Please describe the Life Assured's mental and cognitive abiliites.

(b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

6. Please state and attach copies of all relevant hospital, coronary angiogram report, operation report etc and supply details of laboratory and other tests done.

7. Please provide us with any other additional information that will enable the Company to assess this claim.

Date

Signature & Official Stamp of Doctor

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