

LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

DOCTOR'S STATEMENT FOR:
HIV DUE TO SEXUAL ASSAULT

Please attach copies of the following (if applicable):

1. Antibody tests
2. Proof of sero-conversion
3. All relevant hospital / operation reports, laboratory and test results

* 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 HIV:

| Day | Month | Year |
|-----|-------|------|
| | | |

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

| Symptoms | Duration of Symptoms | Date Symptoms First Started (DD/MM/YYYY) |
|----------|----------------------|--|
| | | |
| | | |
| | | |

(c) What is the source of the above information? Patient / Referring Doctor / Others*

If "Referring Doctor / Others", please specify name & address:

| Name | Address |
|------|---------|
| | |
| | |

(d) Please provide exact diagnosis.

Date

Signature of Doctor

(e) Date when illness was FIRST diagnosed:

| Day | Month | Year |
|-----|-------|------|
| | | |

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

(g) How was the diagnosis made?

(h) Please provide the dates of HIV or antibody test performed and the results of these tests.

| Date of Tests (DD/MM/YYYY) | Types of Tests | Results of Tests |
|-------------------------------|----------------|------------------|
| | | |
| | | |
| | | |

(i) Date when Life Assured first became aware of the diagnosis:

| Day | Month | Year |
|-----|-------|------|
| | | |

3. Was the condition suffered by Life Assured caused directly or indirectly by alcohol or drug abuse?

YES / NO*

If "YES", please give details.

4. What was the exact cause for HIV?

5. (a) If due to sexual assault, was there any Police report made?

YES / NO*

(b) Date of sexual assault:

| Day | Month | Year |
|-----|-------|------|
| | | |

(c) Was there a HIV antibody test conducted within 5 days of assault?

YES / NO*

If "YES", please provide full details, results of tests and copies of tests.

Date

Signature of Doctor

(d) If due to other means e.g. sexual activity, the use of intravenous drugs, please state the exact cause and provide the details.

6. Date on which Life Assured was first diagnosed HIV positive:

| Day | | Month | | Year | |
|-----|--|-------|--|------|--|
| | | | | | |

7. Was the hospital able to ascertain that the assault involved a definite cause of the HIV tainted fluids? YES / NO*
If "YES", please provide full details, results of tests and enclose copies of tests.

8. Was there sero-conversion from HIV negative to HIV positive within 180 days of the assault? YES / NO*
If "YES", please provide full details.

9. Has a cure for HIV / AIDS become available prior to the time the Life Assured was being infected? YES / NO*
If "YES", please provide full details.

10. Is the Life Assured at greater risk of HIV infection due to any aspect of his / her lifestyle, e.g. drug use, sexual orientation? YES / NO*
If "YES", please provide full details.

11. (a) Please describe the Life Assured's mental and cognitive abilities.

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

Date

Signature of Doctor

12. Does the Life Assured have any other medical conditions?

YES / NO*

If "YES", please state the medical condition, date of diagnosis and name & address of treating doctor.

| Medical Conditions | Diagnosis Date (DD/MM/YYYY) | Name and Address of Doctor who treated Life Assured |
|--------------------|--------------------------------|---|
| | | |
| | | |
| | | |

13. Does the Life Assured have any family history?

YES / NO*

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

| Relationship to the Life Assured | Nature of Condition | Age of Onset |
|-------------------------------------|---------------------|--------------|
| | | |
| | | |
| | | |

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

15. Please give details of the Life Assured's habit in relation to alcohol consumption including the amount of alcohol consumption per day and source of information.

16. Please provide any other information which may be of assistance to us in assessing this claim.

Date

Signature & Official Stamp of Doctor