LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
PROGRESSIVE SYSTEMATIC SCLEROSIS (SYSTEMATIC SCLERODERMA) / PROGRESSIVE SCLERODERMA

* 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 this illness: 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) Diagnosis : _____

_____

(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

CCLM
CCLMDOCLAP
Jun 2017

3. (a) Please provide a description of the extent of the illness.

_____

_____

(i) Was the heart involved? YES / NO*

(ii) Were the lungs involved? YES / NO*

(iii) Were the kidneys involved? YES / NO*

(b) Please provide the results of the investigations done.

_____

_____

(i) Serology: _____

(ii) Biopsy (Please attach biopsy report): _____

4. (a) Has the Life Assured previously suffered from any illness related to the present condition? YES/NO*

If "YES", please give details of consultations, the resulting diagnosis, the name and address of the doctor who made these diagnosis and the source of information.

_____

_____

(b) Did the Life Assured consult other doctors for this illness or its symptoms BEFORE he/she consulted you? YES/NO*

If "YES", please give name(s) and address(es) of the doctor(s) whom he / she consulted.

Name of Doctor	Name of Clinic / Hospital and Address

(c) Please provide the names and addresses of any hospital or clinic to which the Life Assured was referred to and the name of the consultants attended.

_____

_____

_____ _____

Date Signature of Doctor

(d) Is the Life Assured suffering or has suffered from any other significant illnesses? YES/NO*

If "YES", please state illness, date of first diagnosis, name and address of attending doctor.

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, X-rays and CAT scans reports.

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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