LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
STROKE

* 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 Stroke: 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 provide full and exact diagnosis of the Life Assured's condition.

_____

_____

(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) Describe the initial episode

(i) Nature of episode: _____

(ii) Date:

Day		Month		Year			

(iii) Duration of acute symptoms: _____

(iv) Is the Life Assured able to return to normal duties? YES / NO*

If "YES", please state when:

Day		Month		Year			

If "NO", please state the Life Assured's latest physical and mental limitations (with date of latest assessment)

Date	Neurological Limits

(b) Was there any neurological deficit 6 weeks after the date of diagnosis of Life Assured's stroke? YES / NO*
If "YES", please describe the neurological deficit.

_____

Is above neurological deficit likely to be permanent? If "YES", please provide details. YES / NO*

_____

(c) Was there evidence of neurological damage at least 6 weeks after the date of diagnosis of Life Assured's stroke and likely to be permanent? YES / NO*

If "YES", please provide details.

_____

_____

(d) Has there been an infarction of brain tissue, haemorrhage or embolisation from an extracranial sourcce? YES / NO*
If "YES", please state which of the above.

_____

_____

_____ _____

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(e) Are the investigation or findings consistent with the diagnosis of a new stroke? YES / NO*

If "YES", please provide details.

_____

_____

(f) Please provide names and addresses of any hospital or clinic to which the Life Assured was referred, together with the names of the consultants attended.

_____

_____

This section is applicable to intracranial aneurysm or arterio-venous malformation condition only.

4. (a) Was an arteriogram carried out? YES / NO*

If "YES", please provide the following:

(i) Date of arteriogram:

Day		Month		Year			

(ii) A copy of the report.

(b) Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? YES / NO*

If "YES", please provide the following:

(i) Date of surgery:

Day		Month		Year			

(ii) Was surgery done via craniotomy? YES / NO*

If "NO", please state the type of surgery performed.

_____

This section is applicable to hydrocephalus condition only.

5. (a) Date of first diagnosis of hydrocephalus:

Day		Month		Year			

(b) Please state the symptoms presented.

_____

_____

_____ _____

Date Signature of Doctor

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(c) How was this diagnosis established? Please include a copy of diagnostic investigation report.

(d) Was the Life Assured's condition of hydrocephalus congenital in nature? YES / NO*
If "NO", please indicate the cause of the hydrocephalus.

(e) Was there any intracranial pressure giving rise to neurological deficits as a result of the hydrocephalus? YES / NO*
If "YES", please indicate the neurological deficits.

(f) Is there surgical insertion of a shunt? YES / NO*

If "YES", please state the date of shunt insertion.

Day		Month		Year			

(g) Was there any other method that could have been used to treat the Life Assured's hydrocephalus? YES / NO*
(i) If "YES", please state the alternative treatment options.

(ii) Why was this treatment method not selected?

6. (a) Did Life Assured suffer from narrowing of the carotid artery? YES / NO*
If "NO", please proceed to Question 7.
If "YES", please provide the following:

(i) Was an arteriography carried out? YES / NO*
If "YES", please provide a copy of report.

(ii) Please state the percentage of narrowing of the carotid artery.

Date

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(iii) Was Endarterectomy carried out to correct the carotid artery? YES / NO*

If "YES", please state the date of surgery.

Day		Month		Year			

If "NO", please state the types of treatment provided.

_____

_____

7. (a) Has the Life Assured previously suffered from all the conditions described above or any related illnesses, e.g hypertension, transient ischaemic attack, angina, other cardiovascular disease, etc? YES / NO*

If "YES", please state:

Illness	Date of First Diagnosis (D/M/Y)	Name and Address of Attending Doctor

(b) Is there anything in the Life Assured's personal medical history which would have increased the risk of a Stroke? YES / NO*

If "YES", please give full details including the date of diagnosis, name and address of attending doctor and source of information.

_____

_____

(c) Is there anything in the Life Assured's family history which would have increased the risk of a Stroke? YES /NO*

If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

_____

_____

(d) 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.

_____

_____

_____ _____

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(e) 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.

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

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

8. (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*

9. (a) Did the Life Assured consult any other doctor for this illness of 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

(b) Please provide the names and addresses of any hospital or clinic to which the Life Assured was referred, together with the names of the consultants attended.

Date

Signature of Doctor

10. Please state and attach copies of all hospital, radiological, CT scanning reports, MRI and supply details of laboratory or any other tests done.

11. 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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