LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
TERMINAL ILLNESS

For Official Use
G E L S –

* Please delete where appropriate

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 the condition resulting in Terminal 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) Please provide full and exact details of the condition causing terminal illness, including dates.

   _____

   _____

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

   (e) Date when Life Assured first became aware that the condition was terminal: 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

3. (a) Details of current symptoms and treatment.

(b) Has active therapy now been rejected in favour of relief of symptoms?

(c) Can you confirm that the advent of death is highly probable within 12 months?

4. (a) Has the Life Assured previously suffered from the condition specified above or any possible related illnesses? YES / NO*
If "YES", please give dates of consultations and the resulting diagnosis.

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

(c) Is there anything in the Life Assured's family history which would have increased the risk of the terminal condition? 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.

(e) 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.

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. (a) 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

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

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7. Please state and attach copies of all hospital reports, laboratory and test results.

_____

_____

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

_____

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_____ _____

Date Signature & Official Stamp of Doctor

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