LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
AIDS DUE TO BLOOD TRANSFUSION / HIV DUE TO BLOOD TRANSFUSION

For Official Use

G E L S –

O A C S –

Please attach copies of the following (if applicable):

1. Antibody test
2. All relevant hospital / operation reports, laboratory and test results

* 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 AIDS / HIV due to Blood Transfusion: 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

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
The Overseas Assurance Corporation Limited (Reg No. 1920 00011W)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

CCLMDOCLAP

(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?

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(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.

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4. (a) Why was the Life Assured receiving blood transfusion?

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(b) Please give the name and address of the hospital where the transfusion took place.

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______________________ ______________________
Date Signature of Doctor

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Jan 2015

(c) On what date did the transfusion take place?

Day		Month		Year			

(d) Date on which Life Assured was first diagnosed HIV positive:

Day		Month		Year			

(e) Was the blood transfusion medically necessary? YES / NO*

(f) Was the blood transfusion given as part of a medical treatment? YES / NO*

(g) Was the patient suffering from Thalassaemia Major or Haempohillia? YES / NO*

(i) If "YES", please state date of diagnosis:

Day		Month		Year			

(ii) Name(s) and address(es) of doctor(s) consulted.

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(iii) Nature of tests performed, date of tests performed and their results.

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(h) Was the hospital able to track the origin of the HIV tainted blood? YES / NO*
If "YES" please provide full details.

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

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6. 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 details.

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______________________________ ______________________________
Date Signature of Doctor

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

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

8. 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

9. 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

10. 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.

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11. 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.

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

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____________________ Date

____________________ Signature & Official Stamp of Doctor

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