LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
APLASTIC ANAEMIA

* Please delete where appropriate

For Official Use

GELS –

OACS –

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 Aplastic Anaemia: 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 / condition: Day Month Year

_____ 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

CCLM
CCLMDOCLAP

Jan 2015

3. (a) Please state the likely cause of this illness / condition, if known.

_____

_____

(b) Is this condition in any way attributable to HIV infection or AIDS? YES / NO*
If "YES", please provide details.

_____

_____

(c) Please provide full details of tests and results which have been performed to establish the diagnosis of Aplastic Anaemia.

_____

_____

4. (d) (i) Was there anaemia? YES / NO*

(ii) Was there neutropenia? YES / NO*

(iii) Was there thrombocytopenia? YES / NO*

Please attach laboratory results in support of the above.

5. Has Life Assured received any of the following treatment?

(a) blood product transfusions YES / NO*

(b) marrow stimulating agents YES / NO*

(c) immunosuppressive agents YES / NO*

(d) bone marrow transplantation YES / NO*

6. Please provide details of treatment administered.

_____

_____

7. Has the Life Assured previously suffered from this or any related illness / condition? YES / NO*

If "YES", please state dates of consultations, resulting diagnosis, the name and address of doctor who made this diagnosis and source of information.

_____

_____

_____ _____

Date Signature of Doctor

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8. (a) Is there anything in the Life Assured's habits or personal medical history which would have increased the risk of Aplastic Anaemia? YES / NO*

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

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

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

9. (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*

10. (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.

11. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

12. 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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