## LIVING ASSURANCE / EPCC CLAIM **DOCTOR'S STATEMENT**



DOCTOR'S STATEMENT FOR:

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e of l	ife Assured:																Ī															
/ Pa	ssport No.:											С	Date	of	Birth	ı (dd	/mn	n/y	ууу	): [									C	Send	ler:	M/F
Are	you the Life A	Assı	ured'	ู้ร เ	ısua	I me	dical o	docto	or?																					`	/ES	S / NO
If "Y	ES", since wh	nat	date'	?	Di	ay [	Month		Year																							
(a)	a) Date when Life Assured first consulted you for the illness that led to Coronary Angioplasty:																															
(b) Please state symptoms presented and date symptoms first appeared.																																
				S	ymp	toms	Pres	ente	d a	t First	С	ons	sulta	tior	n								С	ate	Sy	mp (	tom D/N	ıs Fi /I/Y)	rst :	Star	ted	
	What is the source of this information?										Patient / Referring Doctor / Others*																					
	If "Others", please specify:																															
(c)	Please provi	de	full a	and	l exa	ict de	etails	of the	e di	agnos	sis																					
(Please furnish copies of angiograms, electrocardiograph, echocardiograph, chest x-ray the evidence of coronary artery disease)													ays	ar	nd/c	or o	ther	· lat	te:	st re	sul	ts in	dica	ating								
(d)	Date when il	Ine	ss/o	cor	nditio	on wa	as FIF	RST	diag	gnose	d:				Day	Мс	nth		Ye	ar												
(e)	Diagnosis wa	as 1	first r	ma	de b	y (na	ame o	f dod	ctor	):																						
(f)	Date when L	.ife	Assı	ure	d fir	st be	came	awa	ire (	of the	CO	ondi	ition:	:	Day	/ Mo	onth		Y	ear												
	Da	ate																						_		Sid	gna	—— ture	of	Doc	tor	
	ONAIR IN Asset of the control of the	onary angiopt./ er invasive tree/ ase delete where ap e of Life Assured: c/ Passport No.:  Are you the Life A If "YES", since wh (a) Date when L (b) Please state  What is the s If "Others", p (c) Please provi  (Please furnis the evidence (d) Date when I (e) Diagnosis w (f) Date when L	onary angioplast ER INVASIVE TREATN  ase delete where appropriate of Life Assured:  by Passport No.:  Are you the Life Assured:  If "YES", since what  (a) Date when Life (b) Please state syn  What is the soured:  If "Others", please  (c) Please provide  (Please furnish of the evidence of the evidence of the Diagnosis was the synthesis of the control	ONARY ANGIOPLASTY / A ER INVASIVE TREATMENT ase delete where appropriate e of Life Assured:  C/ Passport No.:  Are you the Life Assured  If "YES", since what date  (a) Date when Life Assured  (b) Please state sympto  What is the source of  If "Others", please s  (c) Please provide full a  (Please furnish copie the evidence of cord  (d) Date when illness / of  (e) Diagnosis was first in  (f) Date when Life Assured	ONARY ANGIOPLASTY / ANGER INVASIVE TREATMENT FOR asse delete where appropriate asse delete where appropriate asse delete where appropriate as delete as delete where appropriate as delete	ONARY ANGIOPLASTY / ANGIOPER INVASIVE TREATMENT FOR Coase delete where appropriate  e of Life Assured:	ase delete where appropriate  e of Life Assured:  Passport No.:  Are you the Life Assured's usual ment of "YES", since what date?  (a) Date when Life Assured first condition was supported by the support of the support of the support of the support of the evidence of coronary artery  (b) Please furnish copies of angiograthe evidence of coronary artery  (c) Please furnish copies of angiograthe evidence of coronary artery  (d) Date when illness / condition was supported by the evidence of coronary artery  (e) Diagnosis was first made by (nate)	ONARY ANGIOPLASTY / ANGIOPLASTY ANER INVASIVE TREATMENT FOR CORONARY asse delete where appropriate  e of Life Assured:  Are you the Life Assured's usual medical of the second of the se	ONARY ANGIOPLASTY (ANGIOPLASTY AND ER INVASIVE TREATMENT FOR CORONARY ART ase delete where appropriate  e of Life Assured:	ONARY ANGIOPLASTY I ANGIOPLASTY AND ER INVASIVE TREATMENT FOR CORONARY ARTER ase delete where appropriate  e of Life Assured:  Are you the Life Assured's usual medical doctor?  If "YES", since what date?  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Symptoms Presented at First Consultation  Date Symptoms Presented at First Consultation  On Many  What is the source of this information?  If "Others", please specify:  (c) Please provide full and exact details of the diagnosis.  (Please furnish copies of angiograms, electrocardiograph, echocardiograph, chest x-rays and/or other lab test rethe evidence of coronary artery disease)  (d) Date when illness / condition was FIRST diagnosed:  Day Month Year  Day Month Year	ONARY ANGIOPLASTY / ANGIOPLASTY AND ER INVASIVE TREATMENT FOR CORONARY ARTERY  see of Life Assured:  O A C S  O	ONARY ANGIOPLEXY ANGIO	ONARY ANGIOPLASTY/ ANGIOPLASTY/ ANGIOPLASTY ANGIOPLAST



3.	(a)	State date and type of procedure performed.													
	(b)	Please specify the coronary arteries involved and the percentage of stenosis as shown below:													
			Coronary Artery	Stenosis:	Percentage of Stenosis										
		(i)	L: Main Stem	YES / NO											
		(ii)	L: Anterior descending artery	YES / NO											
		(iii)	L: Circumflex Artery	YES / NO											
		(iv)	R: Coronary Artery	YES / NO											
	(c)	Please	confirm that the procedure was medically nece	essary.	YES / NO*										
	(d)		Life Assured undergone a similar procedure b		YES / NO*										
		If "YES"	, please state date and place where it was per	formed.											
					s? YES / NO*										
4.	(a)	Did the Life Assured previously suffer from coronary artery disease or any related illness?													
	(b)	Did the	Life Assured consult other doctors for heart dis	sease or its symptoms REFORE I	ne / she consulted you? YES / NO*										
	(6)	If "YES"	•												
			Name of Doctor	Name of Clinic / Hospital and Address											
		Da	ate		Signature of Doctor										
		טפ	ALO		Signature of Doctor										

	(c)	Is there anything in the Life Assured's medical history that would have increased the risk of coronary artery disease? YES / $NO^*$
		If "YES", please give full details including the date of diagnosis, name(s) and address(es) of attending doctors and source of information.
5.	(a)	Is there anything in the Life Assured's family history that would have increased the risk of coronary artery disease? YES / NO*
		If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.
	(b)	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.
	(c)	Is the Life Assured suffering or has suffered from any other significant illnesses?  YES / NO*
6.	(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*
7.		Please state and attach copies of all relevant hospital reports, laboratory and tests results.
8.		Please provide us with any other information that will enable the Company to assess this claim.
	_	Date Signature & Official Stamp of Doctor