LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
BLINDNESS (LOSS OF SIGHT)

* 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 the injury / disease / condition causing Blindness: 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

(g) Is the condition resulting from alcohol or drug misuse? YES / NO*

_____ _____

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

(h) Please state the underlying cause of the Blindness / Loss of sight.

3. (a) Has the Life Assured previously suffered from any eye disease or any related illness? YES / NO*
If "YES", please give dates of consultations, the resulting diagnosis, the name and address of the doctor who made these diagnosis and source of information.

(b) What is the best corrected visual acuity of both eyes at present, using the Snellen Chart?

Left _____ Right _____

(c) Is there any surgery available that could reinstate vision in either or both eyes? YES / NO*
If "YES", please state type of surgery, whether such surgery is recommended for the Life Assured and tentative date of surgery.

(d) Please confirm whether the blindness in either eye OR both eyes is permanent.

This section is applicable to optic nerve atrophy condition only.

4. (a) How was the diagnosis of optic nerve atrophy established?

(b) Are both eyes affected as a result of optic nerve atrophy?

(c) What is the best correct visual acuity using the Snellen Chart?

Left _____ Right _____

_____ _____

Date Signature of Doctor

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(d) Is the Life Assured's condition of optic nerve atrophy in any way resulted from alcohol or drug misuse? YES / NO*

If "YES", please give details.

_____

_____

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

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

_____

_____

(b) Has any of the Life Assured's family (whether living or dead) suffered from eye disease including blindness, cataract, glaucoma or retinitis pigmentosa? YES / NO*

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

_____

_____

(c) 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 the name and address of the attending doctor.

_____

_____

(d) Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

_____

_____

(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.

_____

_____

_____ _____

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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. (a) Did the Life Assured consult other doctors for this injury / disease / condition 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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8. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

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_____

9. 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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