LIVING ASSURANCE / EPCC CLAIM DOCTOR'S STATEMENT



		Lite is Great A member of the OCBC Group		
DOCTOR'S STATEMENT FOR DEAFNESS (LOSS OF HEAR) * Please delete where appropria	NG)	For Official Use G E L S - O A C S -		
Name of Life Assured: NRIC/ Passport No.:	Date of Birth (dd/n	mm/yyyy): Gender: M / F		
Are you the Life Assure If "YES", since what da		YES / NO*		
2. (a) Date when Life Assured first consulted you for Deafness: (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 If "Others", please (c) Please provide full	Patient / Referring Doctor / Others* g deafness/ loss of hearing.			
	sis of "Deafness" was first made:			
	made by (name of doctor): Day sured first became aware of the illness/condition :	Month Year		



Signature of Doctor

Date

3.	(a)	Has the Life Assured previously suffered from any ear disease or any related illness? YES / NO ³ If "YES", please give dates of consultations, the resulting diagnosis and the name and address of the attending doctor.		
	(b)	Is there total loss of hearing of at least 80 decibels in all frequencies of hearing in both ears? If "YES", please provide supporting evidence (e.g audiogram, etc).	YES / NO*	
	(c)	Is the hearing loss irreversible?	YES / NO*	
	(d)	Is there surgery available that could reinstate hearing in either or both ears? If "YES", please state nature of surgery and tentative date of surgery.	YES / NO*	
	(e)	Please state the best corrected hearing frequency for both ears.		
		Left Right		
		Please provide supporting evidence (e.g audiogram, etc).		
Thi	s se	ction is applicable to Cavernous Sinus Thrombosis condition only.		
4.		Date of first diagnosis of Cavernous Sinus Thrombosis:		
	(b)	How was this diagnosis established? (Please include a copy of diagnostic investigation report).		
	(c)	Was surgery carried out to treat Cavernous Sinus Thrombosis? If "YES", please specify:-	YES / NO*	
		(i) Type of surgery:		
		(ii) Date of surgery: Day Month Year University Day Month Year		
			Signature of Doctor	

(d)		Is there other mode of treatment other than the above surgery which could have been used to treat the Life Assured's Cavern Sinus Thrombosis? YES / If "YES", please state the following:-	
		(i) Date of treatment:	
		(ii) Mode of treatment:	
Th	ie ec	ection is applicable to cochlea or auditory nerve conditions only.	
••	113 30	cation is applicable to coefficia of additory herve conditions only.	
5.	(a)	Date of first consultation of cochlea or auditory nerve condition:	
	(b)	Was there total and permanent loss of hearing as a result of cochlea or auditory nerve condition? YES /	NO
	(c)	Was surgical cochlea implant performed for the cochlea or auditory nerve condition? YES / N	۱O*
		If "YES", please state the date of surgery:	
	(d)	Was other surgery carried out to treat the cochlea or auditory nerve condition? YES / If "YES", please specify:	VO'
		(i) Date of surgery:	
		(ii) Type of surgery done:	
	(e)	Is there other mode of treatment which could have been used to treat the Life Assured's cochlea/auditory nerve condition? YES / N	10*
6.	(a)	Is there anything in the Life Assured's lifestyle or personal medical history which would have increased the risk of deafness? YES / N	J O *
		If "YES", please give full details including the illness, the date of diagnosis and source of information.	
	(b)	Is the Life Assured suffering or has suffered from any other significant illnesses? YES / N If "YES", please state illness, date of first diagnosis and name and address of attending doctor.	10*
		Date Signature of Doctor	

7.	(a)	Please describe the Life Assured's mental and cogni	itive abiliites.	
	(b)	Is the Life Assured mentally incapacitated in accorda	nce to the Mental Capacity Act (Chapter 177A of Singapore)?	YES / NO*
8.	(a)	Did the Life Assured consult any other doctor for this illness of its symptoms BEFORE he/she consulted you? If "YES", please give name(s) and address(es) of the doctor(s) whom he/she consulted.		YES / NO*
		Name of Doctor	Name of Clinic / Hospital and Address	
	(b)	Please provide the name(s) and address(es) of any names of the consultants attended.	hospital or clinic to which the Life Assured was referred, tog	ether with the
9.	Plea	se state and attach copies of all relevant hospital repo	orts, laboratory and test results.	
10.	Plea	se provide us with any other additional information tha	at will enable the Company to assess this claim.	
		Date	Signature & Official Stamp o	of Doctor