LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
MAJOR HEAD TRAUMA

* Please delete where appropriate

For Official Use

G E L S –

O A C S –

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 Major Head Trauma: 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) Diagnosis: _____

_____

(d) Date of Accident: Day Month Year

(e) Please give details of the circumstances leading to the Major Head Trauma:

_____

_____

_____ _____

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

(f) Was there reason to suspect that there were contributory circumstances which led to the injury, e.g under the influence of alcohol, fits, etc? YES / NO*

If "YES", please give full details.

_____

_____

(g) Was there police report made with regard to this accident? YES / NO*

If "YES", please attach a copy of the police report.

(h) Did the injury result from a self-inflicted act? YES / NO*

If "YES", please give full details.

_____

_____

(i) Has the Life Assured previously suffered from any illness related to the present condition? YES / NO*

If "YES", please give dates of consultations, the resulting diagnosis, name and address of the doctor and source of information.

_____

_____

3. (a) Please provide exact mode of diagnosis of the brain injury / facial injury / spinal cord injury. (As policy specifies that the brain injury must be demonstrated by a modern scanning or imaging techniques, please attach a copy of the MRI or CT Scan.)

_____

_____

(b) Was there any form of neurological deficit still present 6 weeks after the date of the accident? YES / NO*

If "YES", please state the neurological deficit.

_____

_____

(c) Is this neurological deficit likely to be permanent? YES / NO*

If "NO", please state the date of recovery or date for which the Life Assured is expected to recover from the neurological deficit.

Day		Month		Year			

_____ _____

Date Signature of Doctor

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(d) If the Life Assured is admitted to a hospital, please state:

(i) Date of admission:

Day		Month		Year			

(ii) Date of discharge:

Day		Month		Year			

(iii) Name of hospital admitted into: _____

(e) Was there any surgery done? YES / NO*
If "YES", please provide full details and attach a copy of the surgery note.

_____

_____

(f) Did the Life Assured refuse any form of medical treatment, e.g surgery, which may have prevented or reduced the severity of the impairment? YES / NO*
If "YES", please give full details.

_____

_____

4. (a) If the Life Assured had suffered from facial injury, was there any re-constructive surgery above the neck (restoration or re-constructive of the shape of and appearance of facial structures which are defective, missing or damaged or misshapen)? YES / NO*
If "NO", please proceed to Question 5.
If "YES", please provide the following:-

(i) Is the re-constructive surgery solely for treatment relating to teeth and/or any other dental restoration? YES / NO*
If "NO", please explain the re-constructive surgery in details.

_____

_____

This section is applicable to accidental cervical spinal cord injury only.

5. (a) Has the accidental cervical spinal cord injury resulted in the loss of use of one or more entirelimb for at least 6 weeks? YES / NO*
If "YES", please provide details.

_____

_____

_____ _____

Date Signature of Doctor

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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 any other doctor for this illness of 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 name(s) and address(es) of any hospital or clinic to which the Life Assured was referred, together with the names of the consultants attended.

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8. Please state and attach copies of all relevant hospital report, laboratory and test results.

_____

_____

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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