LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
HEART VALVE SURGERY

* 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 any disease or disorder of the heart valve: 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 details of the heart disease that require heart valve surgery.

_____

_____

(d) Date when heart valve disease requiring surgery 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 condition: Day Month Year

(g) Date when Life Assured first became aware that Heart Valve Surgery was necessary: 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

3. (a) What type of surgery was performed?

_____

_____

(b) Date of Surgery:

Day		Month		Year			

(c) Was it an open-heart surgery? YES / NO*

If "NO", please state exact form of intervention.

_____

_____

(d) Name and address of Hospital.

_____

_____

(e) Name and address of Doctor who performed the surgery.

_____

_____

4. (a) Has the Life Assured previously suffered from any related illness, e.g Hypertension, Angina, other Vascular Disease, Rheumatic Fever, etc? YES / NO*

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

_____

_____

(b) Is there anything in the LIfe Assured's family history which would have increased the risk of hear valve disease? YES / NO*

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

_____

_____

(c) 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.

_____

_____

_____ _____

Date Signature of Doctor

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(d) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*
If "YES", please state illness, date of first diagnosis, name and address of attending doctor.

5. (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*

6. (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 referred.

7. Please state and attach copies of results of cardiac catherterisation/echocardiogram report and other hospital, laboratory and test results.

8. 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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