LIVING ASSURANCE / EPCC CLAIM DOCTOR'S STATEMENT

DOCTOR'S STATEMENT FOR:
FULMINANT HEPATITIS

Please attach copies of the following (if applicable):

1. Ultrasound of the Liver
2. Liver Function Test Results
3. Liver biopsy report
4. Radiological report
5. Endoscopy results, serial liver function tests and laboratory evidence
6. All relevant hospital / operation reports, laboratory and test results

* 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 Fulminant Hepatitis: Day | Month | Year

   (b) Please state symptoms presented and date symptoms first appeared.

Symptoms	Duration of Symptoms	Date Symptoms First Started (DD/MM/YYYY)

   (c) What is the source of the above information? Patient / Referring Doctor / Others*

   If "Referring Doctor / Others", please specify name & address:

Name	Address

   (d) Date when diabetes was FIRST diagnosed: 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

CCLMDOCLAP

(e) Diagnosis was first made by (name of Doctor): ____________________

(f) Date when Life Assured first became aware of the condition:

Day		Month		Year			

3. (a) Please provide full and exact details of the diagnosis including the type(s) of virus involved.

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(b) Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? YES / NO*
If "YES", please give details.

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4. Please confirm on the following:-

(a) Was a liver biopsy performed? YES / NO*

If "YES", please state date of biopsy:

Day		Month		Year			

(b) Is there a submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure? YES / NO*

If "YES", please assist to confirm if there is any of the following:-

(i) Rapid decreasing of liver size? YES / NO*

If "YES", please advise the state of the liver and its lobular architecture.

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(ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework? YES / NO*

If "YES", please advise the extent of the liver necrosis and its lobular architecture.

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____________________ Date

____________________ Signature of Doctor

(iii) Rapid deterioration of liver function test? YES / NO*

If "YES", please provide the results.

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(iv) Deepening jaundice YES / NO*

If "YES", please give full details.

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(v) Signs of hepatic encephalopathy? YES / NO*

If "YES", please give full details.

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5. (a) Was there radiological evidence of oesophageal varices? YES / NO*

(b) Was there evidence of bleeding from the oesophageal varices? YES / NO*
If "YES", please state episode(s) of bleeding.

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6. (a) Please describe the Life Assured's mental and cognitive abiliites.

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(b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

______________________ ______________________

Date Signature of Doctor

7. Does the Life Assured have any other medical conditions? YES / NO*

If "YES", please state medical condition, date of diagnosis and name & address of treating doctor.

Medical Conditions	Diagnosis Date (DD/MM/YYYY)	Name and Address of Doctor who treated Life Assured

8. Does the Life Assured have any family history? YES / NO*

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

Relationship to the Life Assured	Nature of Condition	Age of Onset

9. 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.

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10. Please give details of the Life Assured's habit in relation to alcohol consumption including the amount of alcohol consumption per day and source of information.

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11. Please provide any other information which may be of assistance to us in assessing this claim.

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______________________ Date

______________________ Signature & Official Stamp of Doctor

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