LIVING ASSURANCE / EPCC CLAIM DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
BACTERIAL MENINGITIS

* 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 Bacterial Meningitis: 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.

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   (d) Date when illness / condition was FIRST diagnosed:

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

   (f) Date when Life Assured first became aware of the illness / condition: 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) Has the Life Assured previously suffered from Bacterial Meningitis or any possible related illness? YES / NO*

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

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(b) Please state if there is inflammation of the membranes of the brain or spinal cord. YES / NO*

(c) Please provide details, including dates, of the extent of the neurological deficit.

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(d) Was there any neurological deficit 6 weeks after the date of diagnosis of Life Assured's meningitis? YES / NO*

If "YES", please describe the neurological deficit.

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

If "NO", please provide details.

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(f) Please provide details of investigations performed on the cerebrospinal fluid and blood culture, stating the types of organism found in each.

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(g) Please give details of current treatment.

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(h) Is the Life Assured HIV positive? YES/ NO*

If "YES", please give full details.

____

____

Date

Signature of Doctor

4. (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*

5. (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 attended.

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

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6. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

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7. 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