LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
MAJOR ORGAN TRANSPLANTS / MAJOR ORGANS / BONE MARROW TRANSPLANTATIONS

* 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 any major organ failure that ultimately require organ transplantation: 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) What was the exact diagnosis of the underlying disease leading to the major organ transplantation?

   ____

   ____

   (d) Date when illness / condition that require organ transplant was FIRST diagnosed: Day | Month | Year

   (e) Diagnosis was first made by (name of doctor): Day | Month | Year

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

(g) Has the Life Assured previously suffered from the above or any related illness? YES / NO*
If "YES", please give dates of consultations, the resulting diagnosis, the name and address of the attending doctor.

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3. (a) Prior to the transplantation,

(i) Was there irreversible end-stage failure of the relevant organ? YES/NO*

(ii) What medical treatment or replacement therapy had the Life Assured been receiving, e.g. Dialysis, blood transfusions?

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(iii) When did such treatment commence?

Day		Month		Year			

(b) Date when the major organ / bone marrow was transplanted:

Day		Month		Year			

(c) Was it a bone marrow transplant or a major organ transplant: ____

If major organ transplant, state the organ transplanted and advise whether the entire organ or part of the organ transplanted.

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(d) Was it the first graft? YES / NO*

If "NO", please give date of the first graft:

Day		Month		Year			

(e) How long was the Life Assured on a waiting list for the operation? Since:

Day		Month		Year			

(f) Please provide the name and address of the hospital where the surgery was performed.

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(g) Who performed the surgery? (Please state name and address)

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______________________ ______________________
Date Signature of Doctor

4. For bone marrow transplant:

   Please confirm if the source of the transplanted bone marrow was obtained from another human bone marrow. YES / NO*

5. For small bowel transplant:

   Please confirm if at least one meter of small bowel is transplanted due to intestinal failure. YES / NO*

   If “YES”, please provide details.

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6. For cornea transplant:

   Please confirm that the whole cornea transplant is due to irreversible of scarring and resulted in reduced visual acuity that cannot be corrected with any other methods. YES / NO*

   If “YES”, please provide details.

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7. (a) 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.

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   (b) Is there anything in the Life Assured's personal medical history and family history that would have increased the risk of this illness? YES / NO*

   If “YES”, please give full details including the relationship, nature of illness, date of diagnosis, name and address of the doctor and source of information.

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   ____

   (c) Is the Life Assured suffering from any other significant illnesses? YES / NO*

   If “YES”, please state illness, date of first diagnosis, name and address of attending doctor.

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   ____

______________________ ______________________

Date Signature of Doctor

8. (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*

9. (a) Did the Life Assured consult any other doctors for this injury / disease / condition 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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10. Please state and attach copies of all relevant transplantation, hospital, operation and investigation reports.

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11. 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