LIVING ASSURANCE / EPCC CLAIM DOCTOR'S STATEMENT

DOCTOR'S STATEMENT FOR:
AIDS DUE TO MULTIPLE SCLEROSIS

* 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 Multiple Sclerosis: 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 information? Patient / Referring Doctor / Others*

   If "Others", please specify: ______

   (c) Please provide full and exact diagnosis of Life Assured's condition.

   ______

   ______

   (d) Date when illness/condition 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 illness : 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

3. (a) Please provide details, including dates, of the extent of his/her neurological deficit.

____

____

(b) Were there multiple neurological deficits occuring over a continuous period of at least 6 months? YES / NO*
If “YES”, please give details (including dates of each episode):

____

____

(c) Is there a well-documented history of exacerbations and remissions of said symptoms or neurological deficits? YES / NO*

(d) Please provide details of all investigations performed. Please comment on whether the diagnosis was supported by MRI/CT scan.

____

____

(e) Please give details of current treatment.

____

____

4. Has the Life Assured previously suffered from the condition specified above or any possible related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints ? YES/NO*

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

____

____

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*

______________________ ______________________
Date Signature of Doctor

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

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 attended.

____

____

7. Please state and attach copies of all hospital, MRI/CT scan, 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

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