LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
PARALYSIS (LOSS OF USE OF LIMBS)

Please attach copies of the following (if applicable):

1. All relevant hospital / operation reports, laboratory and test results

* 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 loss of use of limbs: 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) Please provide exact diagnosis.

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

(e) Date when loss of use of limb(s) was FIRST diagnosed:

Day		Month		Year			

(f) Diagnosis was first made by (name of doctor): _____

(g) Date when Life Assured first became aware of the diagnosis:

Day		Month		Year			

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

_____

_____

(i) Please tick the limb(s) involved and confirm if the loss is total & irreversible:

	Total & Irreversible Loss (please circle)
☐ Right upper limb	YES / NO
☐ Right lower limb	YES / NO
☐ Left upper limb	YES / NO
☐ Left lower limb	YES / NO

3. Was there amputation done on the involved limb? YES / NO*

If "YES", please state the date of surgery:

Day		Month		Year			

4. Please indicate the exact location of amputation.

☐ Above Knee ☐ Below Knee

☐ Above Elbow ☐ Below Elbow

5. (a) If there is no surgery, is there total and irreversible loss of use of the affected limb(s)? YES / NO*
If "YES", was it due to disease or injury?

_____

_____

_____ _____

Date Signature of Doctor

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Jan 2015

(b) If due to disease, please provide the following:-

(i) Nature of disease

(ii) Diagnosis of disease

(iii) Date of first diagnosis of disease:

Day		Month		Year			

(iv) Name and address of doctor who treated Life Assured for the disease:

Name	Address

(v) Treatment received and Life Assured's response to treatment.

(vi) Prognosis of the disease.

(c) If due to injury, please provide the following:-

(i) Nature of injury

Date

Signature of Doctor

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(ii) Date of injury:

Day		Month		Year			

(iii) Full description of how Life Assured sustained the injury.

(iv) Diagnosis date:

Day		Month		Year			

(v) Name and address of doctor who treated Life Assured for the disease:

Name	Address

(vi) Treatment received and Life Assured's response to treatment.

(vii) Prognosis of the injury.

(viii) Was the injury self-inflicted? YES / NO*

If "YES", please give full details.

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

Date

Signature of Doctor

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

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

If "YES", please state medical condition, date of diagnosis, name and 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 habit in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

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.

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

Date

Signature & Official Stamp of Doctor

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