LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
PARKINSON'S DISEASE

* 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 Parkinson's disease:: Day Month Year

   (b) Please state symptoms presented and date of symptoms of Parkinson's disease when 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.

   _____

   _____

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

   (e) Please confirm if the Parkinson's Disease is idiopathic in nature? YES / NO*
   (All other forms of Parkinsonism are excluded)

   _____

   _____

_____ _____

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

(f) Please provide details of any investigations performed to confirm the diagnosis of Parkinson's disease.

_____

_____

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

(h) Date when the Life Assured first became aware of Parkinson's disease:

Day		Month		Year			

3. (a) Please provide details, including dates and the extent of neurological deficit suffered.

_____

_____

(b) Please give details of current treatment received for Parkinson's disease.

_____

_____

(c) Did Parkinson's disease result from treatment for any other illness, or is it associated with any other disease, e.g Wilson's disease or Huntington's Chorea? YES / NO*

If "YES", please give full details including date of diagnosis, name and address of the doctor who made the diagnosis and source of information.

_____

_____

(d) Can the condition be controlled with medication? YES / NO*

Please state date when medical treatment first started.

Day		Month		Year			

(e) Are there signs of progressive impairment? YES / NO*

(f) Is the Life Assured able to perform the following daily activities without assistance?

(i) Washing - The ability to wash in the bath or shower (including getting into and out of the bath and shower) or wash satisfactorily by other means. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(ii) Dressing - The ability to put on, take off, secure and fasten all garments and when appropriate, any braces, artificial limbs or other surgical appliances. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

_____ _____

Date Signature of Doctor

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(iii) Transferring - The ability to move from a bed to an upright chair or wheelchair and vice versa. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(iv) Mobility - The ability to move indoors from room to room on level surfaces. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(v) Toileting - The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygience. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

(vi) Feeding - The ability to feed oneself once food has been prepared and made available. YES / NO*

If "NO", for how long has the patient been unable to do so? _____

4. (a) Has the Life Assured previously suffered from Parkinson's disease or any other related illness? YES / NO*

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

_____

_____

(b) 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 the name and address of attending doctor.

_____

_____

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

6. (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.

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

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