LIVING ASSURANCE / EPCC CLAIM **DOCTOR'S STATEMENT**



DOCTOR'S STATEMENT FOR:
PROGRESSIVE SYSTEMATIC SCLEROSIS (SYSTEMATIC SCLERODERMA) /

| PROGRESSIVE SYSTEMATIC SCLEROSIS (SYSTEMATIC SCLERODERMA) / PROGRESSIVE SCLERODERMA * 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/m | nm/yyyy): Gender: M / F | | | | |
| Are you the Life Assured's usual medical doctor? If "YES", since what date? Day Month Year Y | YES/NO* | | | | |
| 2. (a) Date when Life Assured first consulted you for this illness: | Date when Life Assured first consulted you for this illness: | | | | |
| Symptoms Presented at First Consultation | Date Symptoms First Started (D/M/Y) | | | | |
| | | | | | |
| What is the source of this information? If "Others", please specify: | What is the source of this information? Patient/Referring Doctor/Other If "Others", please specify: | | | | |
| (c) Diagnosis : | Diagnosis: | | | | |
| (d) Date when illness/condition was FIRST diagnosed: | Year | | | | |
| (e) Diagnosis was first made by (name of doctor) : | | | | | |
| (f) Date when Life Assured first became aware of the illness : | onth Year | | | | |
| | | | | | |
| | | | | | |
| Date | Signature of Doctor | | | | |



| (a) | Please provide a description of the extent of the illness. | | | |
|-----|---|------------------------|---------------------|--|
| | (i) Was the heart involved? | | YES / NO* | |
| | (ii) Were the lungs involved? | | YES / NO* | |
| | (iii) Were the kidneys involved? | | YES / NO* | |
| (b) | Please provide the results of the investigations | s done. | | |
| | (i) Serology: | | | |
| | (ii) Biopsy (Please attach biopsy report): | | | |
| (a) | Has the Life Assured previously suffered from any illness related to the present condition? YES/NO* If "YES", please give details of consultations, the resulting diagnosis, the name and address of the doctor who made these diagnosis and the source of information. | | | |
| (b) | 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 / Hospi | ital and Address | |
| | | | | |
| | | | | |
| (c) | Please provide the names and addresses of any hospital or clinic to which the Life Assured was referred to and the name of the consultants attended. | | | |
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| | | | | |
| | Date | | Signature of Doctor | |

| | (d) | Is the Life Assured suffering or has suffered from any other significant illnesses? If "YES", please state illness, date of first diagnosis, name and address of attending doc | etor. | YES/NO* | | |
|----|-----|---|-------------------------------|-----------|--|--|
| 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 (C | hapter 177A of Singapore)? | YES / NO* | | |
| 6. | Ple | ase state and attach copies of all relevant hospital, X-rays and CAT scans reports. | | | | |
| 7. | Ple | 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 | | |