LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
LOSS OF SPEECH

* 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 the illness / disease / condition causing Loss of Speech: 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) Please provide full and exact details of the injury / disease / condition causing Loss of Speech.

   _____

   _____

   (d) Date when diagnosis of "Loss of Speech" was first made : Day Month Year

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

   (f) Date when Life Assured first became aware of such disease / condition : Day Month Year

3. (a) Is the loss of speech due solely to the disease/injury to the vocal cord? YES/NO*

   If "YES", please give details:

   (i) disease of vocal cord: _____

   (ii) injury to vocal cord: _____

_____ _____

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

CCLM
CCLMDOCLAP

Jan 2015

(b) Were there any associated neurological or psychiatric conditions contributing to Life Assured's loss of speech? YES/NO*
If "YES", please provide details.

(c) Is the Life Assured undergoing any speech therapy sessions and if so, please detail frequency and duration.

(d) Has there been any improvement in the Life Assured's speech since onset of the condition?

(e) What investigations or tests have been performed to verify the diagnosis of irrecoverable loss of speech?

(f) Please confirm that the loss of speech is total and irreversible. YES/NO*

(g) Has Life Assured been unable to speak for a continuous period of 12 months? YES/NO*

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

(b) Is there anything in the Life Assured's habits or personal medical history which would have increased the risk of loss of speech? YES/NO*
If "YES", please give full details including the date of diagnosis and source of information.

(c) Is the Life Assured suffering or has suffered from any other significant illnesses? YES/NO*
If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

Date

Signature of Doctor

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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*

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 address of any hospital or clinic to which the Life Assured was referred and the names of the consultants attended.

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

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