

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

**DOCTOR'S STATEMENT FOR:  
AIDS COVER OF MEDICAL STAFF / OCCUPATIONALLY ACQUIRED HIV**

For Official Use

G E L S -

Please attach copies of the following (if applicable):

1. Accident report in accordance with established occupational procedures
2. Sero-conversion report
3. All relevant hospital / operation reports, laboratory and test results

\* Please delete where appropriate

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
<input type="text"/>	<input type="text"/>	<input type="text"/>

2. (a) Date when Life Assured first consulted you for HIV:

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

- (b) Please state symptoms presented and date symptoms first appeared.

Symptoms	Duration of Symptoms	Date Symptoms First Started (DD/MM/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

- (c) What is the source of the above information?

Patient / Referring Doctor / Others\*

If "Referring Doctor / Others", please specify name & address:

Name	Address
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

- (d) Please provide exact diagnosis.

Date

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)  
Claims Department  
1 Pickering Street, #01-01 Great Eastern Centre, Singapore 048659

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Aug 2025

Signature of Doctor



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(e) Date when illness was FIRST diagnosed:

Day	Month	Year

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

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(g) How was the diagnosis made?

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(h) Please provide the dates of HIV or antibody test performed and the results of these tests.

Date of Tests (DD/MM/YYYY)	Types of Tests	Results of Tests

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

Day	Month	Year

3. Was the condition suffered by Life Assured caused directly or indirectly by alcohol or drug abuse?

YES / NO\*

If "YES", please give details.

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4. Please provide the following:-

(a) Occupation of the Life Assured

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(b) Employer of the Life Assured

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(c) Please provide full details of how the Life Assured became infected with HIV.

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5. (a) Was the infection with Human Immunodeficiency Virus (HIV) the result of an accident while the Life Assured was carrying out the normal professional duties of occupation in Singapore? YES / NO\*  
If "YES", please provide date and place of accident and the full details.

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- (b) Was the accident reported in accordance with established occupational procedures? YES / NO\*  
If "YES", please give details including where and when it was reported (a copy of the report is mandatory).

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- (c) Did the accident involve a definite source of HIV infected fluids? YES / NO\*

- (d) Was there sero-conversion from HIV negative to HIV positive within 180 days of the accident? YES / NO\*

- (e) Was there a HIV antibody test conducted within 5 days of the accident? YES / NO\*

6. Did the HIV infection result from these other means e.g. sexual activity, the use of intravenous drugs? YES / NO\*  
If "YES", please state the exact causes of the HIV infection when Life Assured infected with HIV.

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7. Has a cure for HIV / AIDS become available prior to the time the Life Assured was being infected? YES / NO\*  
If "YES", please provide details.

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8. Is the Life Assured at greater risk of HIV infection due to any aspect of his / her lifestyle, e.g drug use, sexual orientation?  
If "YES", please provide details. YES / NO\*

9. (a) Please describe the Life Assured's mental and cognitive abilities.

- (b) Is the Life Assured mentally capable of receiving or handling financial matter within the meaning of Section 4 of the Mental Capacity Act 2008\*\* and able to make decisions for himself / herself? YES / NO\*

If "NO",

Please provide the date (DD/MM/YYYY) that Life Assured is certified to be lacking capacity as defined above.

- (c) Please state if the lack of mental capacity is permanent or temporary.

\*\*A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. A person is unable to make a decision for himself if he is unable:

- (1) to understand the information relevant to the decision;
- (2) to retain that information;
- (3) to use or weigh that information as part of the process of making the decision; or
- (4) to communicate his decision (whether by talking, using sign language or any other means).

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

If "YES", please state the medical condition, date of diagnosis and name & address of treating doctor.

Medical Conditions	Diagnosis Date (DD/MM/YYYY)	Name and Address of Doctor who treated Life Assured

Date

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11. 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

12. 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.

13. 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.

14. 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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