

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

**DOCTOR'S STATEMENT FOR:
DEAFNESS (LOSS OF HEARING)**

For Official Use

G E L S -

* 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 Deafness:

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

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

Symptoms Presented at First Consultation	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"/>

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 deafness/ loss of hearing.

(d) Date when diagnosis of "Deafness" was first made:

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

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

(f) Date when Life Assured first became aware of the illness/condition :

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

3. (a) Has the Life Assured previously suffered from any ear disease or any related illness? YES / NO*

If "YES", please give dates of consultations, the resulting diagnosis and the name and address of the attending doctor.

Date

Signature of Doctor

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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- (b) Is there total loss of hearing of at least 80 decibels in all frequencies of hearing in both ears? YES / NO*
If "YES", please provide supporting evidence (e.g audiogram, etc).
-
- (c) Is the hearing loss irreversible? YES / NO*
- (d) Is there surgery available that could reinstate hearing in either or both ears? YES / NO*
If "YES", please state nature of surgery and tentative date of surgery.
-
- (e) Please state the best corrected hearing frequency for both ears.
Left _____ Right _____
Please provide supporting evidence (e.g audiogram, etc).

This section is applicable to Cavernous Sinus Thrombosis condition only.

4. (a) Date of first diagnosis of Cavernous Sinus Thrombosis:

Day	Month	Year

- (b) How was this diagnosis established? (Please include a copy of diagnostic investigation report).
-
-

- (c) Was surgery carried out to treat Cavernous Sinus Thrombosis? YES / NO*
If "YES", please specify:-

- (i) Type of surgery: _____

- (ii) Date of surgery:

Day	Month	Year

- (d) Is there other mode of treatment other than the above surgery which could have been used to treat the Life Assured's Cavernous Sinus Thrombosis? YES / NO*

If "YES", please state the following:-

- (i) Date of treatment:

Day	Month	Year

- (ii) Mode of treatment: _____

Date

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This section is applicable to cochlea or auditory nerve conditions only.

5. (a) Date of first consultation of cochlea or auditory nerve condition:

Day	Month	Year

(b) Was there total and permanent loss of hearing as a result of cochlea or auditory nerve condition?

YES / NO*

(c) Was surgical cochlea implant performed for the cochlea or auditory nerve condition?

YES / NO*

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

Day	Month	Year

(d) Was other surgery carried out to treat the cochlea or auditory nerve condition?

YES / NO*

If "YES", please specify:

(i) Date of surgery:

Day	Month	Year

(ii) Type of surgery done: _____

(e) Is there other mode of treatment which could have been used to treat the Life Assured's cochlea / auditory nerve condition?

YES / NO*

6. (a) Is there anything in the Life Assured's lifestyle or personal medical history which would have increased the risk of deafness?

YES / NO*

If "YES", please give full details including the illness, the date of diagnosis and source of information.

(b) 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.

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

Date

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

8. (a) Did the Life Assured consult any other doctor for this illness of its symptoms BEFORE YES / NO*
he/she consulted you? 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 name(s) and address(es) of any hospital or clinic to which the Life Assured was referred, together with the names of the consultants attended.

9. Please state and attach copies of all relevant hospital reports, laboratory and test results.

10. Please provide us with any other additional information that will enable the Company to assess this claim.

Date

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Signature & Official Stamp of Doctor



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