

For Official Use

[illegible]

- * Please delete where appropriate

[illegible]

- YES / NO*

Day	Month	Year

- | Day | Month | Year |
|-----|-------|------|
| | | |

- | Symptoms | Duration of Symptoms | Date Symptoms First Started (DD/MM/YYYY) |
|----------|----------------------|--|
| | | |
| | | |
| | | |

- Patient / Referring Doctor / Others*

Name	Address

- | Day | | Month | | Year | | | |
|-----|--|-------|--|------|--|--|--|
| | | | | | | | |

-

- | Day | Month | Year |
|-----|-------|------|
| | | |

Signature of Doctor



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3. (a) Please provide full and exact details of the diagnosis including the type(s) of virus involved.

(b) Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? YES / NO*
If "YES", please give details.

4. Please confirm on the following:-

(a) Was a liver biopsy performed? YES / NO*

If "YES", please state date of biopsy:

Day		Month		Year	

(b) Is there a submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure? YES / NO*

If "YES", please assist to confirm if there is any of the following:-

(i) Rapid decreasing of liver size? YES / NO*

If "YES", please advise the state of the liver and its lobular architecture.

(ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework? YES / NO*

If "YES", please advise the extent of the liver necrosis and its lobular architecture.

(iii) Rapid deterioration of liver function test? YES / NO*
If "YES", please provide the results.

(iv) Deepening jaundice YES / NO*
If "YES", please give full details.

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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(v) Signs of hepatic encephalopathy?

YES / NO*

If "YES", please give full details.

5. (a) Was there radiological evidence of oesophageal varices?

YES / NO*

(b) Was there evidence of bleeding from the oesophageal varices?

YES / NO*

If "YES", please state episode(s) of bleeding.

6. (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).

Date

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

If "YES", please state 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

8. 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

9. Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

10. 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.

11. Please provide any other information which may be of assistance to us in assessing this claim.

Date

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Signature & Official Stamp of Doctor



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