LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
HEART ATTACK

* Please delete where appropriate

For Official Use
G E L S –

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 Heart Attack: 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: _____

3. (a) Has the Life Assured previously suffered from a Heart Attack or from the conditions specified above or any related illness, e.g. hypertension, angina or other vascular disease? YES /NO*

If "YES", please state:

(i) Diagnosis: _____

(ii) Date of first diagnosis: Day Month Year

(iii) Name and address of the attending doctor: _____

_____

(b) Date when Life Assured first became aware of the illness: Day Month Year

_____ 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
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

4. (a) Please give full and exact details of the diagnosis.

_____

_____

(b) Please describe the initial episode.

_____

_____

(i) Nature of episode: _____

(ii) Date of initial episode: Day | Month | Year

(iii) Duration of acute symptoms: _____

(iv) Date of return to normal activities: Day | Month | Year

(c) (i) Was there a current history of typical Ischaemic chest pain? YES / NO*

(ii) Were there any changes in the ECG indicative of new myocardial infarct? YES / NO*

(iii) Was there any elevation of cardiac enzyme CK-MB? YES / NO*

(iv) Was there a diagnostic elevation of Troponin (T or I)? YES / NO*

(v) Was there diagnostic elevation of any other cardiac enzymes? YES / NO*

(vi) Was there death of a portion of the heart muscle? YES / NO*

(vii) Was there left ventricular ejection fraction of less than 50% measured three months or more after the event? YES / NO*
(If "YES", please provide date of test and test results)

Date of test and test results (where applicable):

_____

_____

5. (a) Had the Life Assured suffered from cardiac arrhythmia? YES / NO*
(If "NO", please go to Question 6)

If "YES", please advise the following and include a copy of the ECG tracing:-

(i) Type of cardiac arrhythmia presented: _____

(ii) Date of first diagnosis: Day | Month | Year

_____ _____

Date Signature of Doctor

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(b) Was pathway ablation therapy attempted? YES / NO*

(i) If "YES", please state the date of therapy: Day | Month | Year

(ii) If "NO", please state the reason why this is not done.

(c) Was a permanent cardiac pacemaker inserted? YES / NO*

If "YES", please state the date of insertion: Day | Month | Year

(d) Was a permanent cardiac defibrillator inserted? YES / NO*

If "YES", please state the date of insertion: Day | Month | Year

(e) Was there any other mode of treatment which could have been used to treat the Life Assured's cardiac arrhythmia? YES / NO*

(i) If "YES", please specify the alternate mode of treatment.

(ii) Please state the reasons why the alternate mode of treatment was not used.

This section is applicable to pericardial disease condition only.

6. (a) Date of first diagnosis of pericardial diease: Day | Month | Year

(b) Was the surgery performed for the Life Assured's pericardial diease condition? YES / NO*

(i) If "YES", what was the type of surgery performed (e.g pericardectomy, keyhole cardiac surgery, etc)?

(ii) Date of surgery: Day | Month | Year

(c) Was there any other mode of treatment other than the above surgery that could have been performed? YES / NO*

(i) If "YES", what was the type of surgery performed?

Date

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This section is applicable to cardiomyopathy condition only.

7. (a) Date of first diagnosis of cardiomyopathy: Day | Month | Year

(b) Has the Life Assured previously had any cardiac investigation done (e.g ECG, echocardiogram, CT Scan, etc)? YES / NO*

If "YES", please advise the following and include a copy of the investigation report:-

(i) Type of cardiac investigation done: _____

(ii) Date of investigation: Day | Month | Year

(c) Was diagnosis of cardiomyopathy made unequivocally by cardiac echocardiogram? YES / NO*

If "YES", please attach a copy of the echocardiogram report.

If "NO", please specify the basis of diagnosis.

_____

_____

(d) Is the Life Assured's condition of cardiomyopathy in any way related to alcohol misuse? YES / NO*

If "YES", please give details of alcohol consumption, including amount of alcohol consumed, frequency of consumption and types of alcohol consumed.

_____

_____

(e) Does Life Assured have any cardiac or physical impairment which fulfills the New York Heart Association of Cardiac Impairment criteria? YES / NO*

(i) If "YES", please state the class of impairment. Class I/ II/ III/ IV*

(ii) Please provide details of current symptoms.

_____

_____

8. (a) Please give details of the Life Assured's family history which would have increased the risk of heart diseases, including the person's relationship to the Life Assured, nature of illness, date of diagnosis and source of information.

_____

_____

_____ _____

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

(c) Please give details of the Life Assured's habits in relation to alcohol consumption including the duration of alcohol consumption per day and source of information.

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

9. (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*

10. (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 addresses of any hospital or clinic to which the Life Assured was referred to and the names of the consultants referred.

Date

Signature & Official Stamp of Doctor

11. Please state and attach copies of results of any investigations performed, e.g. resting ECGs, exercise stress tests echocardiogram, enzymes assays, isotope imaging, coronary and LV angiography and all relevant hospital reports

12. 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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