

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

**DOCTOR'S STATEMENT FOR:  
HEART VALVE SURGERY**

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 any disease or disorder of the heart valve:

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 heart disease that require heart valve surgery.

(d) Date when heart valve disease requiring surgery was FIRST diagnosed:

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 condition:

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

(g) Date when Life Assured first became aware that Heart Valve Surgery was necessary:

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

3. (a) What type of surgery was performed?

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) Date of Surgery:

Day		Month		Year	

(c) Was it an open-heart surgery?

YES / NO\*

If "NO", please state exact form of intervention.

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(d) Name and address of Hospital.

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(e) Name and address of Doctor who performed the surgery.

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4. (a) Has the Life Assured previously suffered from any related illness, e.g Hypertension, Angina, other Vascular Disease, Rheumatic Fever, etc?

YES / NO\*

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

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(b) Is there anything in the Life Assured's family history which would have increased the risk of heart valve disease?

YES / NO\*

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

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(c) 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.

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(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.

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Date

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Aug 2025

Signature of Doctor



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5. (a) Please describe the Life Assured's mental and cognitive abilities.
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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.
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- (c) Please state if the lack of mental capacity is permanent or temporary.
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\*\*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).

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 addresses of any hospital or clinic to which the Life Assured was referred to and the names of the consultants referred.
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7. Please state and attach copies of results of cardiac catheterisation/echocardiogram report and other hospital, laboratory and test results.
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8. Please provide us with any other additional information that will enable the Company to assess this claim.
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Date

Signature & Official Stamp of Doctor

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