

For Official Use

[illegible]

- * Please delete where appropriate

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

- 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 | | | |
|-----|--|-------|--|------|--|--|--|
| | | | | | | | |

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

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

Date _____

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

For enquiries, call (65) 6248 2888 or visit us at greateasternlife.com > Contact Us

Aug 2025

Signature of Doctor



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

(i) Please tick the limb(s) involved and confirm if the loss is total & irreversible:

Total & Irreversible Loss (please circle)

- | | |
|---|----------|
| <input type="checkbox"/> Right upper limb | YES / NO |
| <input type="checkbox"/> Right lower limb | YES / NO |
| <input type="checkbox"/> Left upper limb | YES / NO |
| <input type="checkbox"/> Left lower limb | YES / NO |

3. Was there amputation done on the involved limb? YES / NO*

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

Day	Month	Year

4. Please indicate the exact location of amputation.

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Above Knee | <input type="checkbox"/> Below Knee |
| <input type="checkbox"/> Above Elbow | <input type="checkbox"/> Below Elbow |

5. (a) If there is no surgery, is there total and irreversible loss of use of the affected limb(s)? YES / NO*
If "YES", was it due to disease or injury?

(b) If due to disease, please provide the following:-

(i) Nature of disease

(ii) Diagnosis of disease

Date

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(iii) Date of first diagnosis of disease:

Day	Month	Year

(iv) Name and address of doctor who treated Life Assured for the disease:

Name	Address

(v) Treatment received and Life Assured's response to treatment.

(vi) Prognosis of the disease.

(c) If due to injury, please provide the following:-

(i) Nature of injury

(ii) Date of injury:

Day	Month	Year

(iii) Full description of how Life Assured sustained the injury.

(iv) Diagnosis date:

Day	Month	Year

(v) Name and address of doctor who treated Life Assured for the disease:

Name	Address

Date

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(vi) Treatment received and Life Assured's response to treatment.

(vii) Prognosis of the injury.

(viii) Was the injury self-inflicted?

YES / NO*

If "YES", please give full details.

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).

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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, name and 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 LifeAssured, 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 habit 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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