

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

**DOCTOR'S STATEMENT FOR:  
PARKINSON'S DISEASE**

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"/>

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

2. (a) Date when Life Assured first consulted you for Parkinson's disease::

(b) Please state symptoms presented and date of symptoms of Parkinson's disease when first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)

What is the source of this information?

Patient / Referring Doctor / Others\*

If "Others", please specify: \_\_\_\_\_

(c) Please provide full and exact diagnosis of the Life Assured's condition.

\_\_\_\_\_  
\_\_\_\_\_

(d) Date when illness / condition was FIRST diagnosed:

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

(e) Please confirm if the Parkinson's Disease is idiopathic in nature?  
(All other forms of Parkinsonism are excluded)

YES / NO\*

\_\_\_\_\_  
\_\_\_\_\_

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](http://greateasternlife.com) > Contact Us

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(f) Please provide details of any investigations performed to confirm the diagnosis of Parkinson's disease.

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(g) Diagnosis was first made by (name of doctor):

(h) Date when the Life Assured first became aware of Parkinson's disease:

Day		Month		Year	

3. (a) Please provide details, including dates and the extent of neurological deficit suffered.

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(b) Please give details of current treatment received for Parkinson's disease.

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(c) Did Parkinson's disease result from treatment for any other illness, or is it associated with any other disease, e.g. Wilson's disease or Huntington's Chorea? YES / NO\*  
If "YES", please give full details including date of diagnosis, name and address of the doctor who made the diagnosis and source of information.

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(d) Can the condition be controlled with medication? YES / NO\*

Please state date when medical treatment first started:

Day		Month		Year	

(e) Are there signs of progressive impairment? YES / NO\*

(f) Is the Life Assured able to perform the following daily activities without assistance?

(i) Washing - The ability to wash in the bath or shower (including getting into and out of the bath and shower) or wash satisfactorily by other means. YES / NO\*

If "NO", for how long has the patient been unable to do so?

(ii) Dressing - The ability to put on, take off, secure and fasten all garments and when appropriate, any braces, artificial limbs or other surgical appliances. YES / NO\*

If "NO", for how long has the patient been unable to do so?

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- (iii) Transferring - The ability to move from a bed to an upright chair or wheelchair and vice versa. YES / NO\*  
If "NO", for how long has the patient been unable to do so?
- 
- (iv) Mobility - The ability to move indoors from room to room on level surfaces. YES / NO\*  
If "NO", for how long has the patient been unable to do so?
- 
- (v) Toileting - The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene. YES / NO\*  
If "NO", for how long has the patient been unable to do so?
- 
- (vi) Feeding - The ability to feed oneself once food has been prepared and made available. YES / NO\*  
If "NO", for how long has the patient been unable to do so?
- 
4. (a) Has the Life Assured previously suffered from Parkinson's disease or any other related illness? YES / NO\*  
If "YES", please state dates of consultations, resulting diagnosis, name and address of the doctor who made these diagnosis and source of information.
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- (b) Is the Life Assured suffering or has suffered from any other significant illness? YES / NO\*  
If "YES", please state illness, date of first diagnosis and the name and address of attending 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 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.
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Date

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(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).

6. (a) Did the Life Assured consult any other doctors for this injury / disease / condition or its symptoms YES / NO\*  
BEFORE 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 names and addresses of any hospital or clinic to which the Life Assured was referred to and the names of the consultants attended.

\_\_\_\_\_  
\_\_\_\_\_

7. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

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\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

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