

DOCTOR'S STATEMENT FOR:
POLIOMYELITIS

For Official Use

GEL 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?

DayMonthYear

2. (a) Date when Life Assured first consulted you for Poliomyelitis:

DayMonthYear

(b) Please state symptoms presented and date symptoms 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) Diagnosis :

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

DayMonthYear

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

(f) Date when Life Assured first became aware of the illness :

DayMonthYear

3. (a) What was the cause of the disease?

Date

Signature of Doctor



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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 > Contact Us

(b) What is the current condition of the Life Assured and what is the prognosis?

(c) Was there impaired motor function or respiratory weakness? YES / NO*

If "YES", please provide details.

(d) What is the nature of treatment?

4. (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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Signature of Doctor



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5.

(a)

Did the Life Assured consult other doctors for this illness or its symptoms BEFORE he/she consulted you?
If "YES", please give name(s) and address(es) of the doctor(s) whom he / she consulted.

YES / NO*

Name of Doctor	Name of Clinic / Hospital and Address

- (b)

Please provide the names and address of any hospital or clinic to which the Life Assured was referred to and the name of the consultants attended.
-

6.

Please state and attach copies of all relevant hospital reports, laboratory and test results.
-

7.

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

Date

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Signature & Official Stamp of Doctor



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