

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

**DOCTOR'S STATEMENT FOR:
PROGRESSIVE SYSTEMATIC SCLEROSIS (SYSTEMATIC SCLERODERMA) /
PROGRESSIVE SCLERODERMA**

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 this illness:

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) Diagnosis : _____

(d) Date when illness/condition 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 illness :

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

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

For enquiries, call (65) 6248 2888 or visit us at [greateasternlife](http://greateasternlife.com) > Contact Us

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3. (a) Please provide a description of the extent of the illness.

(i) Was the heart involved? YES / NO*

(ii) Were the lungs involved? YES / NO*

(iii) Were the kidneys involved? YES / NO*

- (b) Please provide the results of the investigations done.

(i) Serology: _____

(ii) Biopsy (Please attach biopsy report): _____

4. (a) Has the Life Assured previously suffered from any illness related to the present condition? YES / NO*

If "YES", please give details of consultations, the resulting diagnosis, the name and address of the doctor who made these diagnosis and the source of information.

- (b) Did the Life Assured consult other doctors for this illness or its symptoms BEFORE YES / NO*

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

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

Date

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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.

5. (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 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.

(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. Please state and attach copies of all relevant hospital, X-rays and CAT scans reports.

7. 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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