

DOCTOR'S STATEMENT FOR:  
PULMONARY ARTERIAL HYPERTENSION / PULMONARY HYPERTENSION

For Official Use

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\* 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

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

Day

Month

Year

(b) Please state symptoms presented and date symptoms first appeared.

| Symptoms Presented at First Consultation | Date Symptoms First Started<br>(DD/MM/YYYY) |
|--|---|
|  |   |
|  |   |
|  |   |

What is the source of this information?

Patient / Referring Doctor / Others\*

If "Others", please specify:

(c) Please provide full and exact details of the diagnosis.

(d) Is the pulmonary hypertension due to primary or secondary causes?  
Please explain.

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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Signature of Doctor



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(e) Date when illness was FIRST diagnosed:

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

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

\_\_\_\_\_

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

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

3. (a) Is the disease associated with any underlying causes or conditions, or related to any congenital condition? If "YES", please provide full details.

YES / NO\*

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

- (b) Is there presence of right ventricular hypertrophy?

YES / NO\*

Please attach a copy of echocardiogram report.

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

- (c) Was cardiac catheterization carried out to establish the pulmonary hypertension?

YES / NO\*

Please attach a copy of the cardiac catheterization report.

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

- (d) Please give results of any investigations performed, e.g, chest X-rays, ECG's echocardiograph, cardiac catheterization and any other tests. Please attach copies of the reports or test results.

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

- (e) (i) Does Life Assured have any cardiac/physical impairment which fulfills the New York Heart Association of Cardiac Impairment criteria?

YES / NO\*

- (ii) If "YES", please state the class of impairment.

Class I / II / III / IV\*

- (iii) Please provide details of current symptoms.

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

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(f) (i) What treatment has been administered?

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(ii) What treatment is currently being administered?

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(g) Has transplantation been considered?

YES / NO\*

If "YES", please provide full details.

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4. (a) Is the Life Assured suffering or has suffered from any other significant illnesses?

YES / NO\*

If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

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(b) Did the Life Assured consult any other doctor 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 name(s) and address(es) of any hospital or clinic to which the Life Assured was referred to, together with the names of the attending doctor(s).

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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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(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. Please state and attach copies of all hospital reports, cardiac catheterisation reports, other laboratory and test results.

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

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Signature & Official Stamp of Doctor



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