DEATH CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

* Please delete where appropriate

For Official Use

G E L S –

O A C S –

Name of Life Assured:

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

1. (a) Date of deceased's first consultation with you: Day Month Year

(b) Date of subsequent consultation: _____

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

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

What is the source of this information? Life Assured/ Referring Doctor/ Others*

If "Others", please specify the name of the person and relationship to the Life Assured:

_____

(d) Date when deceased first became aware of symptoms: Day Month Year

(e) Diagnosis: _____

_____

(f) Date of FIRST diagnosis: Day Month Year

(g) Date diagnosis was made known to the deceased: Day Month Year

(h) What was the exact information conveyed to the deceased?

_____

(i)

Treatment given to Deceased	Date(s) of Treatment

_____ _____

Date Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
The Overseas Assurance Corporation Limited (Reg No. 1920 00011W)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

CCLM
CCLMDOCDTH

Jan 2015

2. (a) What other significant condition did the deceased suffered from?

Brief Description of Illness(es)	Date(s) Diagnosed (DD/MM/YY)	Name and Address of Attending Doctor

(b) Was there any predisposing cause of the deceased's death (e.g. alcohol, narcotics etc, family history or occupation)? YES / NO*

If "YES", please give full details including the date of commencement and source of information.

_____

_____

3.

Cause of Death	Approximate Interval Between Onset and Death			
	Years	Months	Days	Hours
(a) _____ due to (or as a consequence of)				
(b) _____ due to (or as a consequence of)				
(c) _____ due to (or as a consequence of)				

4. Did the deceased consult any other doctor(s) before consulting you? YES / NO*

If "YES", please give his/ her name and address.

_____

_____

5. 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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