

**DEATH CLAIM
DOCTOR'S STATEMENT**

* Please delete where appropriate

For Official Use

G E L 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

(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)
<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?

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
<input type="text"/>	<input type="text"/>	<input type="text"/>

(e) Diagnosis:

(f) Date of FIRST diagnosis:

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

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

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

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

(i)

Treatment given to Deceased	Date(s) of Treatment
<input type="text"/>	<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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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

