PAYSECURE/ WAIVER OF PREMIUMS (DISABILITY) 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. Are you the Life Assured's regular doctor? YES / NO*

   If "YES", since what date? Day Month Year

2. (a) Date of first consultation for the current condition: Day Month Year

   (b) Date of subsequent consultations: _____

   (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) Diagnosis: _____

   _____

   _____

   (e) Date of FIRST Diagnosis: Day Month Year

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

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

   (h) What was the exact information conveyed to the Life Assured?

   _____

   _____

3. (a) Is the condition a result of an accident? YES / NO*

   If "YES", please state:

   (i) Date of accident: Day Month Year (ii) Time of accident: _____

_____ _____

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
CCLMDOCPAY

Jan 2015

(iii) Place of accident:

_____

(iv) Detailed description of the accident:

_____

_____

(v) Detailed description of the injuries:

_____

_____

(b) Was the accident reported to the police? YES / NO*
If "YES", please provide the name of the police division and police officer-in-charge's name.

_____

(c) Was the Life Assured under the influence of alcohol/ drug at the time of accident? YES / NO*
If "YES", what was the blood alcohol content/ drug type and quality consumed:

_____

(d) Is the disability due to pregnancy, self-inflicted or caused/ aggravated by the taking of alcohol or unprescribed drugs? YES / NO*
If "YES", please state the exact cause.

_____

_____

(e) Type of treatment including any operations performed and his/ her response.

_____

_____

4. (a) Please describe fully the nature and severity of the Life Assured's disabilities.

_____

_____

_____

(b) Is his/ her disability progressive, stationary or improving?

_____

(c) Is full recovery expected? YES / NO*

If "YES", please state approximate date: Day | Month | Year

If "NO", please state the extent of recovery and approximate date: Day | Month | Year

_____ _____

Date Signature of Doctor

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(d) Is the Life Assured able to perform all Activities of Daily Living (ADL) without assistance? YES / NO*

If "NO", please state which one(s) he/ she is unable to perform independently.

The 6 ADLs include feeding, mobility, continence, bathing, dressing and toileting.

(e) Does the Life Assured have full power of all limbs? YES / NO*

If "NO", please specify which limb(s) do(es) not have full power and the current power of limbs.

(f) Please give full details with respect to the Life Assured's mental and congnitive abilities.

(g) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

(h) What is the Life Assured's occupation before disability?

(i) What is the nature of duties of Life Assured's current occupation?

(j) How does the Life Assured's disability prevent him/ her from performing the above listed duties of his/ her disability?

(k) Is the Life Assured able to perform all the normal duties of his/ her usual occupation? YES / NO*

If "YES", when is he/ she expected to return to his usual occupation?

Month		Year			

(l) If he/ she is unable to return to his/ her usual occupation, is he/ she able to engage in any other occupation? YES / NO*

If "YES",

(i) What types of occupation can he/ she engage in?

(ii) When can he/ she expect to engage in these occupations?

Month		Year			

Date

Signature of Doctor

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5. ACTIVITIES OF DAILY LIVING ("ADL") FUNCTION

Notes:

"**NO assistance**" means the Life Assured requires no assistance to perform the ADL.

"**SOME assistance**" means the Life Assured requires some assistance of another person up to 74% of the time to perform the ADL.

"**SUBSTANTIAL assistance**" means the Life Assured requires another person at least 75% of the time to perform the ADL.

"**FULL assistance**" means the Life Assured is not able to perform the ADL even with the aid of the special equipment, and always requiring the physical help of another person throughout the entire ADL.

(i) **Washing/ Bathing**
(ability to wash in bath or shower or by other means to maintain personal cleanliness.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(ii) **Dressing**
(ability to dress and undress and put on and take off any medical appliances usually worn.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(iii) **Bladder/ Bowel Continence**
(ability to manage bowel and bladder function with or without the use of catheters, incontinence pads or other artificial aids to maintain personal hygiene.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(iv) **Mobility**
(ability to move indoors from room to room on level surfaces.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

_____ _____

Date Signature of Doctor

(v) **Transferring**
(ability to move from a bed to an upright chair or wheelchair and vice versa.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(vi) **Feeding**
(ability to ingest food when it is made available.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(b) Please state the basis of your opinion of the Life Assured's ADL ability (e.g. face to face assessment, report from patient, report from relative, etc).

_____

_____

(c) What tests did you use to establish the Life Assured's function for each of the ADLs (standardised functional assessments, observation of patient performing ADL-specific tasks, etc)?

_____

_____

(d) When did you last see the Life Assured and for how long?

_____

_____

(e) In what environment did you last see the Life Assured (e.g. home, hospital, nursing home, relative's home, etc)?

_____

_____

_____ _____

Date Signature of Doctor

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6. MEDICAL HISTORY

(a) Did the Life Assured consult other doctors for this illness or its symptoms BEFORE he/ she consulted you? YES / NO*
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

(b) Is the patient suffering or has suffered from any other significant illnesses? YES / NO*
If "YES", please state.

Illness	Date of First Diagnosis (DD/MM/YY)	Name and Address of Attending Doctor

7. Please provide us with any other additional information that will enable the Company to assess this claim. Enclose copies of laboratory test results.

_____

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor

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