

# Congenital Illness Doctor's Statement



## Important Notes:

- (1) Please attach copies of relevant laboratory reports to assist us in assessing the claim
- (2) Date format in **DD/MM/YYYY**
- (3) \*Please delete or circle where appropriate.

Name of Insured Child:

NRIC / Passport No.\*:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: M / F\*

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Name of Insured Child's Mother:

NRIC / Passport No.\*:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

1 Are you the Insured Child's usual medical doctor?

YES / NO\*

If "YES", since what date?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2 Date when Insured Child,

(a) first consulted you for current condition:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(b) date of subsequent consultation(s):

3 (a) Please provide symptoms presented and date symptoms first appeared.

Symptoms presented at first consultation	Date symptoms first started (DD/MM/YYYY)

(b) What is the source of the information on the Insured Child, please provide details (Name and Relationship):

4 Please tick the appropriate box for the Diagnosis or Congenital Illness that the Insured Child is claiming on.

i. Absence of Two Limbs		x. Congenital Abnormalities of the Kidney and Urinary Tract (CAKUT)		xix. Patent Ductus Arteriosus	
ii. Albinism		xi. Congenital Blindness		xx. Retinopathy of Prematurity	
iii. Anal Atresia		xii. Congenital Cataract		xxi. Spina Bifida	
iv. Atrial Septal Defect		xiii. Congenital Deafness		xxii. Tetralogy Fallot	
v. Biliary Atresia		xiv. Congenital Diaphragmatic Hernia		xxiii. Tracheo-Esophageal Fistula or Esophageal Atresia	
vi. Cerebral Palsy		xv. Congenital Hypertrophic Pyloric Stenosis		xxiv. Transposition of Great Vessel	
vii. Cleft Palate / Cleft Lip		xvi. Development Dysplasia of the Hip		xxv. Truncus Arteriosus	
viii. Club Foot		xvii. Down's Syndrome		xxvi. Ventricular Septal Defect	
ix. Coarctation of Aorta		xviii. Infantile Hydrocephalus			

Signature and Official Stamp 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

Date



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The diagram consists of three pairs of boxes, each pair connected by a vertical line. The first pair is connected by a single vertical line. The second pair is connected by a single vertical line. The third pair is connected by a single vertical line. The pairs are separated by slashes (/).

YES / NO\*

(a) Date when the diagnosis was informed: 

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YES / NO\*

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YES / NO\*

		/			/						HR	MIN
		/			/							

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Was the Insured Child's illness arising directly or indirectly from:

YES / NO\*

YES / NO\*

YES / NO\*

YES / NO\*

YES / NO\*

YES / NO\*

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YES / NO\*

Medical Condition(s)	Diagnosis Date	Name and Address of Doctor who treated Insured Child

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11 Does the Insured Child's parents have any family history?

YES / NO\*

If "YES", please provide details including relationship to the Insured Child's parent, nature of condition and age of onset.

Relationship to Life Assured	Nature of Condition	Age of Onset

12 Please provide details on the habit of Insured Child's mother in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

13 Is the Insured Child's mother mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)?

YES / NO\*

If "YES", since when:

/

/

14 Please attach copies of relevant laboratory reports to assist us in assessing the claim.

Please complete questions under the related Diagnosis or Congenital Illness.

<b>i. Absence of Two Limbs</b>	
1 Is the Insured's Child born with congenital absence of	
(a) Both arms at or above the wrist?	YES / NO*
(b) Both legs at or above the ankle joints?	YES / NO*
(c) One arm at or above the wrist and one leg at or above the ankle joint?	YES / NO*
<b>ii. Albinism</b>	
1 Was the inherited condition present at birth which results in partial or total absence of the pigment melanin?	YES / NO*
2 Was the diagnosis of Albinism made by a specialist in the relevant medical field?	YES / NO*
<b>iii. Anal Atresia</b>	
1 Was there an absence of a normal anal opening?	YES / NO*
2 Was the diagnosis of Anal Atresia made by a medical specialist in the relevant medical field?	YES / NO*
3 Was surgery performed to correct the abnormality?	YES / NO*
If "YES", please provide the date and name of surgical procedure performed:	
<hr/>	
4 Please provide a copy of the operation report or discharge summary.	
<b>iv. Atrial Septal Defect</b>	
1 Was there an abnormal opening in the inter-atrial septum that allows free communication of blood between the right and left atrial?	YES / NO*
2 Was the diagnosis of Atrial Septal Defect diagnosed by a cardiologist and confirmed on echocardiogram?	YES / NO*
3 Was an invasive surgery performed to correct the condition?	YES / NO*
If "YES", please provide the date and name of surgical procedure performed:	
<hr/>	
4 Please provide a copy of the echocardiogram report and operation report / discharge summary.	
<b>v. Biliary Atresia</b>	
1 Was there presence of scarred or blocked bile ducts outside and inside of the liver?	YES / NO*
2 Was there damage to the liver that leads to scarring, loss of liver tissue and function, and cirrhosis?	YES / NO*
3 Was surgery performed to correct the abnormality?	YES / NO*
If "YES", please provide the date and name of surgical procedure performed:	
<hr/>	
4 Please provide a copy of the operation report or discharge summary.	
<b>vi. Cerebral Palsy</b>	
1 Was there persisting, non-progressive disorder of movement resulting from damage to the brain before, during or immediately after birth?	YES / NO*
2 Was the diagnosis of Cerebral Palsy made by a medical specialist in the relevant medical field?	YES / NO*
<b>vii. Cleft Palate / Cleft Lip</b>	
1 Does the Insured's Child have congenital fissure of the palate associated with cleft lip?	YES / NO*

Signature and Official Stamp of Doctor

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Please complete questions under the related Diagnosis or Congenital Illness.

**viii. Club Foot**

- 1 Does the Insured Child have congenital abnormality of the lower extremity? YES / NO\*
- If "YES", please provide if the following were present:
- (a) Plantar flexion YES / NO\*
- (b) Inversion of the heel hind foot and forefoot YES / NO\*
- (c) Adduction of the forefoot YES / NO\*
- 2 Was the club foot bilateral? YES / NO\*

**ix. Coarctation of Aorta**

- 1 Was there presence of congenital heart defect involving a narrowing of the aorta? YES / NO\*
- 2 Was the diagnosis of Coarctation of Aorta diagnosed by a cardiologist and confirmed on echocardiogram? YES / NO\*
- 3 Was an invasive surgery performed to correct the condition? YES / NO\*
- If "YES", please provide the date and name of surgical procedure performed:
- \_\_\_\_\_
- 4 Please provide a copy of the echocardiogram report and operation report / discharge summary.

**x. Congenital Abnormalities of the Kidney and Urinary Tract (CAKUT)**

- 1 Was there Congenital Abnormalities of the Kidney and Urinary Tract (CAKUT) affecting the kidneys, the bladder, the ureters and the urethra? YES / NO\*
- 2 Please advise if the following were present:
- (a) Was there persistent proteinuria with urine protein to creatinine ratio of above 0.2 mg / mg. YES / NO\*
- (b) Was there elevated estimated creatinine clearance based on serum creatine for a period of at least 6 months. YES / NO\*
- (c) Has surgery been performed to correct the condition? YES / NO\*
- If "YES", please provide the date and name of surgical procedure performed:
- \_\_\_\_\_
- (d) Please provide a copy of the operation report or discharge summary.
- 3 (a) Was the unequivocal diagnosis made by an appropriate medical Specialist in the relevant medical field and confirmed on renal scan or magnetic resonance imaging? YES / NO\*
- (b) Please provide a copy of the renal scan or magnetic resonance imaging report.

**xi. Congenital Blindness**

- 1 Please confirm if there is total and irreversible loss of all vision in both eyes at birth. YES / NO\*
- 2 Was the diagnosis of Congenital Blindness made by a specialist in the relevant field and confirmed by relevant tests? YES / NO\*
- 3 Is the above complete loss of sight arising from congenital, developmental or other causes? YES / NO\*
- If "YES", please provide details: \_\_\_\_\_

4		Left Eye	Right Eye
	Date of total and permanent loss of sight		
	Visual acuity		
	Visual field		

- 5 Please provide a copy of all relevant tests.

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Please complete questions under the related Diagnosis or Congenital Illness.

**xii. Congenital Cataract**

- 1 Please confirm if there are clouding of the lens of both eyes at birth. YES / NO\*
- 2 Was there complete absence of the sense of sight from birth? YES / NO\*
- 3 Was surgery performed for cataract removal? YES / NO\*
- If "YES", please provide the hospitalisation period:
- Date of Admission: 


 / 


 / 

- Date of Discharge: 


 / 


 / 


**xiii. Congenital Deafness**

- 1 Please confirm if there is complete loss of hearing in both ears at birth. YES / NO\*
- 2 Was the diagnosis of Congenital Deafness made by a specialist in the relevant field and confirmed by relevant tests? YES / NO\*
- 3 If "YES", please provide the hearing threshold test performed, and the results for left and right ear in decibels (dB):
- \_\_\_\_\_
- 4 Is the above complete loss of hearing arising from congenital, developmental or other causes? YES / NO\*
- If "YES", please provide details:
- \_\_\_\_\_

**xiv. Congenital Diaphragmatic Hernia**

- 1 Was there presence of abdominal organs in the chest cavity at birth? YES / NO\*
- 2 Was the diagnosis of Congenital Diaphragmatic Hernia made by a medical specialist in the relevant medical field? YES / NO\*
- 3 Was there characteristic chest radiograph finding of herniated abdominal contents into the thorax? YES / NO\*
- 4 Was surgery performed to correct the above condition? YES / NO\*
- If "YES", please provide the date and name of surgical procedure performed:
- \_\_\_\_\_
- 5 Please provide a copy of the chest radiograph report confirming the diagnosis.

**xv. Congenital Hypertrophic Pyloric Stenosis**

- 1 Please advise if the following were present:
- (a) Thickening of the pylorus YES / NO\*
- (b) Near-complete obstruction of the gastric outlet YES / NO\*
- (c) Forceful vomiting YES / NO\*
- 2 Was the diagnosis of Congenital Hypertrophic Pyloric Stenosis made by an appropriate Specialist in the relevant medical field? YES / NO\*
- 3 Was surgery performed to correct the abnormality? YES / NO\*
- If "YES", please provide the date and name of surgical procedure performed:
- \_\_\_\_\_
- 4 Please provide a copy of the operation report or discharge summary.

**xvi. Development Dysplasia of the Hip**

- 1 Is the Insured's Child born with dislocation or instability of the hip? YES / NO\*
- 2 Did the above lead to hip dysplasia? YES / NO\*
- 3 Was surgery performed to correct the abnormality? YES / NO\*
- If "YES", please provide the date and name of surgical procedure performed:
- \_\_\_\_\_
- 4 Please provide a copy of the operation report or discharge summary.

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**xvii. Down's Syndrome**

- |   |           |
|---|-----------|
| 1 Was there a specific chromosomal abnormality, consisting of a variable constellation of abnormalities caused by a triplication or translocation of chromosome 21, established by chromosome analysis? | YES / NO* |
| 2 Does the insured child exhibit the following:   |           |
| (a) mental retardation  | YES / NO* |
| (b) retarded growth   | YES / NO* |
| (c) flat hypoplastic face with a short nose   | YES / NO* |
| (d) prominent epicanthic skin folds   | YES / NO* |
| (e) small low set ears with prominent antihelix   | YES / NO* |
| (f) fissured and thickened tongue   | YES / NO* |
| (g) laxness of joint ligaments  | YES / NO* |
| (h) pelvic dysplasia  | YES / NO* |
| (i) broad hands and feet  | YES / NO* |
| (j) stubby fingers  | YES / NO* |
| (k) transverse palmar crease  | YES / NO* |
| 3 Please provide a copy of the chromosome analysis report.  |           |

**xviii. Infantile Hydrocephalus**

- |  |           |
|--|-----------|
| 1 Was there enlargement of the cerebrospinal fluid (CSF) spaces resulting from obstruction of flow pathway between the secretion sites in the ventricles and absorption sites in the subarachnoid space? | YES / NO* |
| 2 Have the Insured Child undergone shunt placement?  | YES / NO* |
| If "YES", please provide the date of surgery and a copy of the operation report:   |           |
| <hr/>  |           |

**xix. Patent Ductus Arteriosus**

- |   |           |
|---|-----------|
| 1 Was Patent Ductus Arteriosus diagnosed by a cardiologist and confirmed on echocardiogram? | YES / NO* |
| 2 Was an invasive surgery performed to correct the condition?                               | YES / NO* |
| If "YES", please provide the date and name of surgical procedure performed:                 |           |
| <hr/>   |           |
| 3 Please provide a copy of the operation report or discharge summary.                       |           |

**xx. Retinopathy of Prematurity**

- |   |           |
|---|-----------|
| 1 Was the Insured's Child diagnosed to have Retinopathy resulting from premature birth?       | YES / NO* |
| 2 Did the Insured's Child undergo laser, cryotherapy or surgical procedure for the condition? | YES / NO* |
| If "YES", please provide the date and name of surgical procedure performed:                   |           |
| <hr/>   |           |
| 3 Please provide a copy of the operation report or discharge summary.                         |           |

**xxi. Spina Bifida**

- |  |           |
|--|-----------|
| 1 Was there been congenital defective closure of the bone encasement of the spinal cord? | YES / NO* |
| 2 Please advise if Spina Bifida is associated with the following:                        |           |
| a) A meningeal cyst (meningocele), or  | YES / NO* |
| b) A cyst containing both meninges and spinal cord (meningomyelocele), or                | YES / NO* |
| c) Only spinal cord (myelocele)  | YES / NO* |

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Please complete questions under the related Diagnosis or Congenital Illness.

**xxii. Tetralogy Fallot**

- 1 Was there an anatomic abnormality with a combination of:
  - (a) Severe or total obstruction to right ventricular outflow tract (pulmonary stenosis), YES / NO\*
  - (b) Ventricular septal defect, YES / NO\*
  - (c) Dextroposition of the aorta with septa override, and YES / NO\*
  - (d) Right ventricular hypertrophy YES / NO\*
- 2 Was the diagnosis of Tetralogy Fallot diagnosed by a cardiologist and confirmed on echocardiogram? YES / NO\*
- 3 Was an invasive surgery performed to correct the condition? YES / NO\*  
If "YES", please provide the date and name of surgical procedure performed:  
\_\_\_\_\_
- 4 Please provide a copy of the echocardiogram.

**xxiii. Tracheo-Esophageal Fistula or Esophageal Atresia**

- 1 Was there an abnormal connection (fistula) between the esophagus and the trachea? YES / NO\*
- 2 Was the congenital Esophageal atresia (or oesophageal atresia) affecting the alimentary tract? YES / NO\*
- 3 Was surgery performed to correct the abnormality? YES / NO\*  
If "YES", please provide the date and name of surgical procedure performed:  
\_\_\_\_\_
- 4 Please provide a copy of the operation report or discharge summary.

**xxiv. Transposition of Great Vessel**

- 1 Was there complete transposition of the aorta and pulmonary artery such that
  - (a) right ventricle of the heart pumps blood from the systemic veins into the aorta, and YES / NO\*
  - (b) left ventricle pumps blood from the pulmonary veins into the pulmonary artery YES / NO\*
- 2 Was the diagnosis of Transposition of Great Vessel diagnosed by a cardiologist and confirmed on echocardiogram? YES / NO\*
- 3 Was an invasive surgery performed to correct the condition? YES / NO\*  
If "YES", please provide the date and name of surgical procedure performed:  
\_\_\_\_\_
- 4 Please provide a copy of the echocardiogram report.

**xxv. Truncus Arteriosus**

- 1 Was there a large ventricular septal defect over a large over which single great vessel (truncus) arises? YES / NO\*
- 2 Was the diagnosis of Truncus Arteriosus diagnosed by a cardiologist and confirmed on echocardiogram? YES / NO\*
- 3 Was an invasive surgery performed to correct the condition? YES / NO\*  
If "YES", please provide the date and name of surgical procedure performed:  
\_\_\_\_\_
- 4 Please provide a copy of the echocardiogram report.

**xxvi. Ventricular Septal Defect**

- 1 Was there an opening in the inter-ventricular septum that allows free communication of blood between the right and left ventricle? YES / NO\*
- 2 Was the diagnosis of Ventricular Septal Defect diagnosed by a cardiologist and confirmed on echocardiogram? YES / NO\*
- 3 Was an invasive surgery performed to correct the condition? YES / NO\*  
If "YES", please provide the date and name of surgical procedure performed:  
\_\_\_\_\_
- 4 Please provide a copy of the echocardiogram report.

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