

Life Woman Enhanced Benefits Claim 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 Life Assured:

NRIC / Passport No.*:

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Gender: M / F*

Date of Birth:

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1 Are you the Life Assured's usual medical doctor?

If "YES", since what date?

YES / NO*

		/			/												
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2 Date when Life Assured first consulted you for this illness:

		/			/												
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3 Please provide symptoms presented and date symptoms first appeared.

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

4 Please tick the appropriate box for the Diagnosis that the life assured is claiming on.

i. Carcinoma in situ of the breast		vi. Reconstructive surgery of facial disfigurement due to accident or assault		xi. Tetralogy of Fallot	
ii. Carcinoma in situ of the cervix uteri		vii. Hospitalisation due to complications of pregnancy or childbirth		xii. Transposition of the Great Vessels	
iii. SLE with lupus nephritis		viii. Incubation of new-born baby for more than 5 days		xiii. Disseminated Intravascular coagulation	
iv. Hysterectomy required as a result of cancer		viii. Down's syndrome			
v. Ectopic Pregnancy		x. Spina bifida			

(a) Actual diagnosis:

(b) Date of diagnosis:

		/			/												
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(c) Name and Speciality of the doctor where diagnosis was first made:

(c) Date when Policyholder / Life Assured became aware of the diagnosis:

		/			/												
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(d) Were there any underlying illnesses/ conditions that attributed to the current medical condition?

YES / NO*

If "YES", please provide full details of condition (including the nature of condition and the date of onset) and describe how it attributed to the above medical condition.

Signature and Official Stamp of Doctor

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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5 Was the Life Assured hospitalised for surgical procedure or treatment? YES / NO*

If YES, please provide:

(a) Date and Time of Admission:

		/			/					HR	MIN
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(b) Date and Time of Discharge:

		/			/						
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(c) Name of Hospital:

6 How many months was the Life Assured pregnant at the time of hospitalisation?

7 Was the hospitalisation due to complications of pregnancy or childbirth?

8 Does the Life Assured have any other medical conditions?

YES / NO*

If "YES", please provide the medical condition, date of diagnosis and name & address of treating doctor:

Medical Condition(s)	Diagnosis Date	Name and Address of Doctor consulted

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

10 Please provide any other information which may be of assistance to us in assessing this claim.

Signature and Official Stamp of Doctor

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