

Pregnancy and Childbirth Complications 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?

YES / NO*

If "YES", since what date?

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2 Date when Life Assured first consulted you for current pregnancy:

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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 or Pregnancy and Childbirth Complication that the life assured is claiming on.

i. Abruptio Placentae		vii. Fatty Liver of Pregnancy		xiii. Postpartum Haemorrhage requiring Hysterectomy	
ii. Amniotic Fluid Embolism		viii. Gestational Diabetes resulting in Foetal Macrosomia and Neonatal Hypoglycaemia		xiv. Pre-Eclampsia or Eclampsia	
iii. Antepartum and Intrapartum Haemorrhage		viii. HELLP Syndrome		xv. Still Birth (after 28 Weeks of Gestation)	
iv. Choriocarcinoma and Hydatiform Mole		x. Miscarriage or Termination of Pregnancy due to Life Threatening Condition		xvi. Twin-to-Twin Transfusion Syndrome	
v. Disseminated Intravascular Coagulation (DVC)		xi. Placenta Increta/Percreta		xvii. Uterine Rupture	
vi. Ectopic Pregnancy		xii. Placenta Previa		xviii. Vasa Previa	

(a) Date of diagnosis:

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(b) 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

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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
		/							
		/							

(b) Date and Time of Discharge:

(c) Name of Hospital:

6 Was the Life Assured's condition arising directly or indirectly from any of the following:

(a) The Life Assured is carrying 3 or more fetuses in a single pregnancy? YES / NO*

(b) An elective termination of pregnancy or abortion? YES / NO*

(c) A voluntary or malicious act? YES / NO*

(d) Activities which are potentially life-threatening or where there is a risk of bodily injury to the Life Assured? YES / NO*

(e) Pregnancy complications from fertility treatment excluding IVF, OFSI, IUI and ICI? YES / NO*

(f) Alcoholism, drug abuse or a deliberate act of taking poison? YES / NO*

(g) AIDS and all illness or diseases caused by or related to the Human Immunodeficiency Virus? YES / NO*

(h) Sexually-transmitted diseases? YES / NO*

If "YES" for any of the above, please provide the details including diagnosis date, name of doctor and clinic who first diagnosed the Life Assured with the above and a copy of test result(s) (Where applicable).

7 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 who treated Life Assured

8 Does the Life Assured have any family history? YES / NO*

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset:

Relationship to Life Assured	Nature of Condition	Age of Onset

9 Please provide details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habit, number of cigarettes smoked per day and source of information.

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

If "YES", since when:

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Please complete questions under the related Diagnosis or Pregnancy and Childbirth Complications.

i. Abruption Placentae

- 1 Was there Premature separation of the placenta from the uterine wall after the twentieth (20th) week gestation? YES / NO*
- 2 Have the above caused foetal death or required emergency caesarean section? YES / NO*
- 3 Please provide the date of surgery: / /

ii. Amniotic Fluid Embolism

- 1 Was there entering of amniotic fluid into the maternal circulation? YES / NO*
- 2 Have the above caused life threatening pulmonary edema or cardiac arrest in the Mother? YES / NO*
- 3 Have the above caused foetal death? YES / NO*

iii. Antepartum and Intrapartum Haemorrhage

- 1 Was there severe abnormal bleeding from the female genital tract at or after twenty (20) weeks of pregnancy before or during childbirth? YES / NO*
- 2 Please provide the underlying cause of the antepartum and intrapartum haemorrhage
- _____
- _____

iv. Choriocarcinoma and Hydatiform mole

- 1 Was occurrence of choriocarcinoma and / or molar pregnancy established by histological evidence? YES / NO*
- If "YES", please provide a copy of the histology report.
- 2 Please provide the medical field of the specialist who diagnosed the condition:
- _____

v. Disseminated Intravascular Coagulation (DVC)

- 1 Did disseminated intravascular coagulation (DVC) occur as a result of pregnancy complication? YES / NO*

vi. Ectopic Pregnancy

- 1 Was there implantation of a fertilised ovum outside the uterine cavity? YES / NO*
- 2 Was the ectopic pregnancy terminated? YES / NO*

vii. Fatty Liver of Pregnancy

- 1 Was there severe acute fatty liver during pregnancy? YES / NO*
- 2 Please advise if the following were present:
- (a) Renal impairment? YES / NO*
- If "YES", please provide details and readings:
- _____
- _____

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Please complete questions under the related Diagnosis or Pregnancy and Childbirth Complications.

(b) Was there coagulopathy?

YES / NO*

If "YES", please provide details:

(c) Was there persistent elevation of bilirubin above 150 umol/L (10 mg/dL) for a period of at least 5 days?

YES / NO*

If "YES", please provide the Date and Reading taken each day:

	Day 1	Day 2	Day 3	Day 4	Day 5
Date					
Result					

3 Was there liver damage in the presence eclampsia, pre-eclampsia and viral hepatitis?

YES / NO*

If "YES", please provide details:

viii. Gestational Diabetes resulting in Foetal Macrosomia and Neonatal Hypoglycaemia

1 Is the Gestational Diabetes Mellitus (GDM) diagnosed for the first time during this pregnancy?

YES / NO*

2 Did the Life Assured's GDM screening results meet the following values:

(a) Fasting Plasma Glucose >5.1 mmol/L (91.8 mg/dL)

YES / NO*

(b) 1-hour Plasma Glucose \geq 10.0 mmol/L (180 mg/dL) following a 75-gram oral glucose load

YES / NO*

(c) 2-hour Plasma Glucose >8.5 mmol/L (153 mg/dL) following a 75-gram oral glucose load

YES / NO*

Please provide copies of the GDM screening results.

3 Please advise if the following present:

(a) Did the Life Assured give birth to a baby with foetal macrosomia?

YES / NO*

Please provide the birth weight of the baby: _____

(b) Did the baby have neonatal hypoglycaemia?

YES / NO*

(c) Was the baby's plasma glucose level less than 1.65 mmol/L (30 mg/dL) in the first 24 hours of life?

YES / NO*

4 Please provide the name and speciality of doctor who made the diagnosis of GDM and above outcomes:

5 Does the Life Assured have any prior history of GDM, diabetes mellitus or impaired glucose tolerance prior to this pregnancy? If "YES", please provide details (date of diagnosis, diagnosis, medication and dosage, name and address of doctor who made the diagnosis:

YES / NO*

viii. HELLP Syndrome (Haemolysis, Elevated Liver enzymes, Low Platelet count)

1 Was there a life-threatening pregnancy complication from a variant or complication of pre-eclampsia occur during the later stages of pregnancy, or after childbirth?

YES / NO*

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Please complete questions under the related Diagnosis or Pregnancy and Childbirth Complications.

2	Please advise if the following were present:	
	a) Haemolysis,	YES / NO*
	b) Elevated Liver Enzymes,	YES / NO*
	c) Low Platelets	YES / NO*
3	Please provide the name and speciality of doctor who made the diagnosis of HELLP Syndrome and above outcomes:	

x. Miscarriage or Termination of Pregnancy due to Life Threatening Condition		
1	Did death of the foetus (unborn baby) occur after 13 weeks of pregnancy?	YES / NO*
2	Was the death of the foetus due to a sudden unforeseen and involuntary event?	YES / NO*
	If "YES", please provide details:	

3	Was the death of the foetus due to termination of pregnancy as a direct consequence of a life-threatening condition of the life assured? If "YES", please provide details:	YES / NO*

4	Date of surgery:	<div style="display: flex; align-items: center; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
xi. Placenta Increta / Percreta		
1	Was there abnormal adherent of the placenta to the myometrium?	YES / NO*
2	Did this lead to severe haemorrhage requiring surgical removal of the placenta?	YES / NO*
	If "YES", please provide the date of surgery.	
	<div style="display: flex; align-items: center; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	
3	Was Placenta Increta or Percreta established via histology evidence and confirmed by an obstetrician?	YES / NO*
	If "YES", please provide a copy of histology report.	
xii. Placenta Previa		
1	Was there presence of placental tissue extending over the internal cervical os, resulting in an indication for caesarean delivery.	YES / NO*
2	Did this lead to an indication for caesarean delivery	YES / NO*
3	Was the diagnosis of placenta previa confirmed by an obstetrician?	YES / NO*
xiii. Postpartum Haemorrhage requiring Hysterectomy		
1	Was there on-going bleeding secondary to an unresponsive and atonic uterus, ruptured uterus or large cervical laceration extending into the uterus?	YES / NO*

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2	Did this lead to a hysterectomy? If "YES", please provide the date of the surgery and submit a copy of operation report or discharge summary with procedure performed.	YES / NO*
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