JUNIOR LIVING ASSURANCE / MAXCARE JUNIOR CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
MAJOR ORGAN TRANSPLANT

* Please delete where appropriate

For Official Use

GELS –

OACS –

Name of Life Assured:

NRIC/ Passport No.:

Date of Birth (dd/mm/yyyy):

Gender: M / F *

1. (a) Are you the Life Assured's usual medical doctor? YES / NO*

(b) If "YES", since what date? Day Month Year

(c) Over what period do your records extend? From Day Month Year to Day Month Year

(d) If you are not the Life Assured's usual medical doctor, please provide the name, address and qualification of the Life Assured's usual medical doctor.

2. (a) Date when Life Assured consulted you for this illness: Day Month Year

(b) Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (D/M/Y)

What is the source of this information? Patient / Referring Doctor / Others*

If "Others", please specify: _____

(c) What was the exact diagnosis of the underlying disease leading to the major organ transplant?

_____

_____

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
CCLMDOCJLA

Jan 2015

3. (a) Please provide the full and exact details of the diagnosis.

_____

_____

(b) Date when illness was FIRST diagnosed:

Day		Month		Year			

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

(d) Date when the Life Assured first became aware of the condition:

Day		Month		Year			

(e) Date when the Life Assured's PARENT first became aware of the condition:

Day		Month		Year			

4. (a) Prior to the transplantation,

(i) Was there irreversible end-stage failure of the relevant organ? YES/NO*

(ii) What medical treatment or replacement therapy had the Life Assured been receiving, e.g. dialysis, blood transfusions?

_____

_____

(iii) When did such treatment commence?

Day		Month		Year			

(b) Date when the major organ / bone marrow was transplanted:

Day		Month		Year			

(c) Was it a bone marrow transplant or a major organ transplant: _____

If major organ transplant, state the organ transplanted: _____

(d) Was it the first graft? YES/NO*

If "NO", please give date of the first graft:

Day		Month		Year			

(e) How long had the Life Assured been on waiting list for the operation? S ince :

Day		Month		Year			

(f) Please provide the name and address of the hospital in which the surgery was performed.

_____

_____

_____ _____

Date Signature of Doctor

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(g) Who performed the surgery? (Please state name and address.)

5. For bone marrow transplant:

Please confirm that the transplanted bone marrow was obtained from another human bone marrow. YES/NO*

6. (a) Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of information.

(b) Is there anything in the Life Assured's personal medical history and family history that would have increased the risk of this illness? YES/NO*

If "YES", please give full details including the relationship, nature of illness, date of diagnosis, name and address of the doctor and source of information.

(c) Is the Life Assured suffering from any other significant illnesses? YES/NO*

If "YES", please state illness, date of first diagnosis, name and address of attending doctor.

7. Please state and attach copies of the relevant transplantation, hospital, operations and investigation reports.

8. Has the Life Assured previously suffered from the condition specified above or any releated illness? YES / NO*

If “YES”, please give details including dates of consultations and the resulting diagnosis.

Date

Signature of Doctor

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9. 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

10. Please provide dates and results of all HIV and antibody tests done. Please also attach copies of all relevant laboratory reports.

11. Does the Life Assured have any personal history of any other major medical or psychiatric condition? YES / NO*

If "YES", please give details including nature of condition, date of onset, treatment received and current status of the condition.

12. Does the Life Assured have any family history of any major medical condition? YES / NO*

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

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

Date

Signature & Official Stamp of Doctor

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