

JUNIOR LIVING ASSURANCE / MAXCARE JUNIOR CLAIM
DOCTOR’S STATEMENT



DOCTOR’S STATEMENT FOR:
RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT

For Official Use

GEL S -

* Please delete where appropriate

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 (DD/MM/YYYY)

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

If “Others”, please specify:

(c) Diagnosis:

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

(f) State which of the Jones criteria the Life Assured satisfies.

(g) Please provide details, with supporting evidence, of any streptococcal infection.

4. (a) Is there any heart valve incompetence? If so, please state valve(s) involved with details including degree of incompetence.

(b) What is the cause of the heart valve incompetence?

5. Please provide details of all investigations performed and treatment prescribed. Please attach a copy of the laboratory / investigation results.

Date

Signature of Doctor



6. 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

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

8. 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.

9. 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.

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

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
Aug 2025

Signature & Official Stamp of Doctor

