

**HOSPITALISATION CLAIM
DOCTOR'S STATEMENT**

For Official Use

G E L S -

O A C S -

Name of Life Assured:

NRIC/ Passport No.:

1. (a) Has the Life Assured consulted any other doctors/ hospitals prior to first consultation with you? YES / NO*
If "YES", please provide name and address of the doctor(s)/ hospital(s).

- (b) Are you the Life Assured's usual medical doctor? YES / NO*

If "YES", since when?

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

2. (a) Date of first consultation for the current condition:

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

- (b) Date(s) of subsequent consultation: _____

- (c) Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YY)

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

If "Others", please specify the name of the person and relationship to the Life Assured:

- (d) Diagnosis: _____

- (e) Date of FIRST Diagnosis:

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

- (g) Date diagnosis was made known to the Life Assured:

Day	Month	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

- (h) What was the exact information conveyed to the Life Assured?

Date

Signature of Doctor



(i) Is the condition a result of an accident? YES / NO*

(i) If "YES", describe in detail how the accident happened. _____

(ii) Date of accident:

Day		Month		Year	

(iii) Was the Life Assured under the influence of alcohol/ drugs at the time of accident? YES / NO*
If "YES", please state the blood alcohol content/ drug type and quantity consumed:

(iv) Did the injuries result from a self-inflicted act? YES / NO*
If "YES", please give full description.

(j) Type of treatment/ medication given and the response.

(k) Please tick if the following were done/ will be done.

Gamma Knife Radiotherapy Stereotactic Radiotherapy Erythropoietin
 Chemotherapy Kidney dialysis Cyclosporin Immunotherapy

(l) Is the current treatment related to the following conditions? YES / NO*

If "YES", please tick the box(es):

Infertility Subfertility Abortion Birth control Sterilisation
 Impotence test or treatment
 Pregnancy, childbirth, miscarriage or their sequelae Complications of Pregnancy or childbirth
 Alcoholism Drug addiction Drug abuse
 Routine eye examination Refractive errors of the eyes
 Depression Mental disorder Functional disorder
 Hereditary conditions Birth defects Congenital sickness or abnormalities
 Obesity Weight reduction Weight improvement
 AIDS or any illness caused by or related to HIV Sexually-transmitted disease

Date

Signature of Doctor

If you have ticked any of the boxes, please give full details.

(m) Is the Life Assured still on follow-up treatment? YES / NO*
If "YES", please specify the type of treatment/ medication.

(n) How frequent does the Life Assured seek treatment since discharge from hospital?

(o) What is the expected length of follow up?

3. Please state the periods of hospitalisations.

Name of Hospital	Period(s) of Hospitalisation		Period(s) of Intensive Care	
	From	To	From	To

4. (a) Was surgery performed for this condition? YES / NO*
If "YES", please specify.

Nature of Surgical Operation(s)	Date(s) Performed (DD/MM/YY)	Surgical Table No.

(b) Is further surgery likely to be required? YES / NO*

If "YES",

Day	Month	Year

(i) please specify the tentative date of surgery:

(ii) please specify the type of surgery to be performed:

Date

Signature of Doctor

(c) Is the surgery performed an elective cosmetic or plastic surgery? YES / NO*
 If "YES", please provide details.

5. (a) Has the Life Assured previously suffered from the same illness in respect of which he/ she is claiming now? YES / NO*
 If "YES", please state:

Day	Month	Year

(i) Date when illness was first diagnosed:

(ii) Name and address of the doctor who first treated him/ her.

(iii) Has the Life Assured fully recovered from the previous illness before the current episode? YES / NO*

(b) Has the Life Assured been admitted to any hospital before, either for the same or different cause? YES / NO*
 If "YES", please state.

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) of Attending Doctor(s)

(c) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*
 If "YES", please state.

Brief Description of Illness(es)	Date(s) of First Diagnosis (DD/MM/YY)	Name & Address of Attending Doctor

6. Please provide us with any other additional information that will enable the Company to assess this claim.

Date

Signature & Official Stamp of Doctor