

TERMINAL ILLNESS CLAIM - DOCTOR'S STATEMENT

(To be completed by the Life Assured's attending medical specialist)



Important Notes:

- Please attach copies of the following, where applicable:
 - All relevant investigation reports such as histopathology or biopsy report, imaging studies, laboratory and other reports
 - Referral letter (if any).
 - The cost of the medical certification will be borne by the patient.
- *Please circle/delete where appropriate.

Details of Life Assured

Full Name: _____

NRIC / Passport No.(for foreigner only):

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Details of Medical Consultation

- 1 Please state symptoms presented and date symptoms first appeared.

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

- 2 Date when the Life Assured first consulted you for the condition?

DD	MM	YYYY								
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- 3 (a) Date when illness / condition was FIRST diagnosed:

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- (b) Date when Life Assured first became aware of the diagnosis:

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

- (d) Please provide full and exact diagnosis of the Life Assured's condition.

- (e) Is Life Assured's condition related to Cancer?

YES / NO*

If "YES", please provide details:

- (i) Diagnosis and the tumour classification e.g TNM classification.

- (ii) Were there any distant metastases?

YES / NO*

If "YES", please state the organ(s) impacted and since when (DD/MM/YYYY).

- (iii) Is Life Assured's condition re-current?

YES / NO*

If "YES", please provide the date (DD/MM/YYYY) of first diagnosis of the recurrent condition.

- 4 Is Life Assured's condition in any way related to:

- (a) AIDS, AIDS-related complex or infection by HIV?

YES / NO*

- (b) Congenital anomaly or defect?

YES / NO*

- (c) Alcohol abuse or misuse?

YES / NO*

- (d) Drug abuse or use of drug not prescribed by registered medical practitioner?

YES / NO*

- (e) Attempted suicide or self-inflicted injuries?

YES / NO*

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 Please provide the treatment rendered since the diagnosis of current medical condition in the table below:

Start date	End date	Treatment (Name & Dosage)	Purpose of treatment	Patient's response to treatment

6 Have the Life Assured undergone all possible medical treatments?

YES / NO*

If "YES", please provide details.

7 Please state the treatment regimen in the next 12 months including the name and purpose of the treatment.

8 Do you certify the Life Assured to be terminally ill, where despite all the reasonable medical treatments, the Life Assured is expected to live for no more than 12 months?

YES / NO*

If "YES",

(a) Please state the date (DD/MM/YYYY) the Life Assured is assessed to be terminally ill as defined above.

(b) Please provide supporting medical evidence of the condition, possible medical treatment and the prognosis after undergone such treatments and certify that the Life Assured is expected to live for no more than 12 months despite all the possible medical interventions.

If "NO", does the Life Assured have a reduced life expectancy?

YES / NO*

(i) If Yes, please specify the number of years: _____

(ii) Does the Life Assured fulfil one or both of the conditions below:

(a) Disease is of moderate to severe stage (e.g. Stage 3 and above)

YES / NO*

(b) Has significant loss ($\geq 70\%$) of organ function?

YES / NO*

9 (a) Date of Life Assured most recent consultation / examination with you.

DD	MM	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

(b) Please describe fully the nature and severity of the Life Assured's disabilities.

(c) Is Life Assured's disability progressive, stationary, or improving? Please provide details.

Signature and Official Stamp of Doctor

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(d) Is Life Assured able to perform all the 6 Activities of Daily Living (ADL) without assistance? YES / NO*

The 6 ADLs include Washing, Dressing, Feeding, Toileting, Mobility or Transferring.

If "NO", please specify which one(s) he/she requires assistance, whether permanent or temporary and the level of assistance required (mild, moderate, maximum).

Activities of Daily Living	Permanent full / maximum assistance	Temporary full / maximum Assistance	Minimal / moderate help / supervision only
Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(e) Does the Life Assured have full power of all limbs? YES / NO*

If "NO", please specify which limb(s) do(es) not have full power and the current power of limbs.

10 (a) What is the Life Assured's usual occupation? Please provide details.

(b) Is the Assured able to perform all the normal duties of his usual occupation? YES / NO*

(c) If the Life Assured is unable to return to his / her usual occupation, is he / she reasonably suited for any other job(s) based on his / her medical condition, education, and experience? YES / NO*

If "YES", please provide examples of such other job(s)

If "NO", please provide the reason(s).

11 (a) Is the Life Assured's physically / mentally incapacitated to take part in any employment permanently? YES / NO*

(b) Is the disability "total and permanent" and such that there is neither than nor at any time thereafter any work, occupation or profession that the person concerned can ever sufficiently do or follow to earn or obtain any wages, compensation or profit? YES / NO*

If "YES", please state the date that Life Assured is certified to be incapacitated to take part in any employment permanently (DD/MM/YYYY)

(c) Please provide Life Assured's disability that prevent him / her from taking part in any employment or to earn or obtain wages, compensation, or profit permanently.

(d) If the incapacity of the Life Assured cannot be confirmed upon examination or ascertain at this moment, would you recommend to review his / her condition in the near future? YES / NO*

If "YES", what is the appropriate time period for the Company to re-assess this claim?

Signature and Official Stamp of Doctor

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12 Is the Life Assured mentally capable of receiving or handling financial matter within the meaning of Section 4 of the Mental Capacity Act 2008** and able to make decisions for himself / herself?

YES / NO*

If "NO",

Please provide the date (DD/MM/YYYY) that Life Assured is certified to be lacking capacity as defined above.

Please state if the lack of mental capacity is permanent or temporary.

**A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. A person is unable to make a decision for himself if he is unable:

- (1) to understand the information relevant to the decision;
- (2) to retain that information;
- (3) to use or weigh that information as part of the process of making the decision; or
- (4) to communicate his decision (whether by talking, using sign language or any other means).

13 Did the Life Assured consult any other doctor for this illness of its symptoms BEFORE he/she consulted you? YES / NO*

If YES, please provide details.

Date of consultation	Name and Address of Doctor

14 Is the Life Assured suffering or has suffered from similar condition or other significant illnesses?

YES / NO*

If YES, please provide details.

Date of First Diagnosis	Medical Condition	Name and Address of Attending Doctor

15 Does the Life Assured have any family history?

YES / NO*

If YES, please provide details.

Relationship to Life Assured	Age of Onset	Name and Address of Attending Doctor

Signature and Official Stamp of Doctor

Date

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