PERMANENT DISABILITY CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

* Please delete where appropriate

For Official Use

G E L S –

O A C S –

Name of Life Assured:

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

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

If "YES", since what date? Day Month Year

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

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

(c) Please state the 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

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

(g) Date diagnosis was made to the Life Assured: Day Month Year

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

_____

3. (a) Life Assured's occupation before disability: _____

_____ _____

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
CCLMDOCTPD

May 2016

(b) Nature of duties of current occupation.

(c) How does the Life Assured's disability prevent him/ her from performing the above listed duties of his/ her occupation?

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

If "YES", please state the date of accident: Day Month Year Time of accident:

Describe in detail how the accident happened.

(b) Was the accident reported to the police? YES / NO*

If "YES", please provide the name of the police division and the police officer-in-charge's name.

(Please enclose a copy of the police report.)

(c) 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:

(d) Is the condition self-inflicted? YES / NO*

If "YES", please provide full details.

(e) Type of treatment including any operations performed and his/ her response.

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

Date

Signature of Doctor

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(b) Is his/ her disability progressive, stationary or improving?

(c) Is full recovery expected? Day | Month | Year YES / NO*

If "YES", please state approximate date:

If "NO", please state the extent of recovery and approximate date.

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

The 6 ADLs include feeding, mobility, transferring, bathing, dressing and toileting

If "NO", please state which one(s) he/ she is unable to perform independently.

(e) Is the Life Assured confined to a home, hospital or other institution that provides constant care and medical attention? YES / NO*

If "YES", since what date? Day | Month | Year

(f) 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.

If the disability is pertaining to total & permanent loss of sight. please complete Question 6

Q6 The loss of sight must be permanent and irreversible, even with the use of visual aids.

Please describe the nature and cause of permanent loss of sight

Right eye

Date of total and permanent loss of sight : Day | Month | Year

Date of last review: Day | Month | Year

Visual acuity :

Visual field :

Visual acuity:

Visual field :

Left eye

Date of total and permanent loss of sight : Day | Month | Year

Date of last review: Day | Month | Year

Visual acuity :

Visual field :

Visual acuity:

Visual field :

Date

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If the disability is pertaining to loss of physical function/ severance of limbs, please complete Q7

Please select all that is applicable.

Q7 (a) Severance at the ankle

Left Date of severance: Day Month Year

Right Date of severance: Day Month Year

Please describe the nature and cause of severance:

(b) Severance at the wrist

Left Date of severance: Day Month Year

Right Date of severance: Day Month Year

Please describe the nature and cause of severance:

Please select if there is total and permanent loss of use (loss of all physical function) of the following

Left upper limb

Date certified total and permanent loss of use: Day Month Year

Please describe the nature and cause

Left lower limb

Date certified total and permanent loss of use: Day Month Year

Please describe the nature and cause

Right upper limb

Date certified total and permanent loss of use: Day Month Year

Please describe the nature and cause

Right lower limb

Date certified total and permanent loss of use: Day Month Year

Please describe the nature and cause

Date

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8 Please give full details with respect to the Life Assured's mental abilities and cognition.

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

If "YES", when is he/ she expected to return to his usual occupation? Day Month Year

(i) If he/ she is unable to return to his/ her usual occupation, is he/ she able to engage in any other occupation? YES / NO*

If "YES",

(i) What types of occupation can he/ she engage in?

(ii) When is he/ she expected to engage in these occupations? Month Year

10. (a) 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	Date of First Consultation

(b) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*

If "YES", please state.

Illness	Date of First Diagnosis (DD/MM/YY)	Name and Address of Attending Doctor

(c) (i) Is the Life Assured physically or mentally incapacitated from ever continuing in any employment? YES / NO*

(ii) If Yes, when did such disability commence? Day Month Year

(iii) If the Life Assured is mentally incapacitated, please state if he/ she is mentally capable of receiving or handling money. YES / NO*

Date

Signature & Official Stamp of Doctor

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(d) (i) 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*

(ii) If Yes, when did such disability commence?

Day		Month		Year			

(e) Is the Life Assured terminally ill? YES / NO*

(f) Terminal Illness

In your opinion, is the patient terminally ill (life expectancy of 1 year or less)? Yes/No

If Yes, please indicate the date the patient is assessed to be terminally ill

Day		Month		Year			

:

11. 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?

12. Please provide us with any other additional information that will enable the Company to assess this claim. Enclose copies of laboratory test results.

_____

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor

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