LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
CORONARY ANGIOPLASTY / ANGIOPLASTY AND
OTHER INVASIVE TREATMENT FOR CORONARY ARTERY

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

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

2. (a) Date when Life Assured first consulted you for the illness that led to Coronary Angioplasty: 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) Please provide full and exact details of the diagnosis.

   _____

   _____

   (Please furnish copies of angiograms, electrocardiograph, echocardiograph, chest x-rays and/or other lab test results indicating the evidence of coronary artery disease)

   (d) Date when illness / condition was FIRST diagnosed: Day Month Year

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

   (f) Date when Life Assured first became aware of the condition: Day Month Year

_____ _____

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: claims-sg@greateasternlife.com Website: greateasternlife.com

CCLM
CCLMDOCLAP

Jan 2014

3. (a) State date and type of procedure performed.

_____

_____

(b) Please specify the coronary arteries involved and the percentage of stenosis as shown below:

	Coronary Artery	Stenosis:	Percentage of Stenosis
(i)	L: Main Stem	YES / NO	
(ii)	L: Anterior descending artery	YES / NO	
(iii)	L: Circumflex Artery	YES / NO	
(iv)	R: Coronary Artery	YES / NO	

(c) Please confirm that the procedure was medically necessary. YES / NO*

(d) Has the Life Assured undergone a similar procedure before? YES / NO*

If "YES", please state date and place where it was performed.

_____

_____

4. (a) Did the Life Assured previously suffer from coronary artery disease or any related illness? YES / NO*

_____

_____

(b) Did the Life Assured consult other doctors for heart disease 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 Signature of Doctor

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(c) Is there anything in the Life Assured's medical history that would have increased the risk of coronary artery disease? YES / NO*

If "YES", please give full details including the date of diagnosis, name(s) and address(es) of attending doctors and source of information.

5. (a) Is there anything in the Life Assured's family history that would have increased the risk of coronary artery disease? YES / NO*

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

(b) 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.

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

6. (a) Please describe the Life Assured's mental and cognitive abiliites.

(b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

7. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

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

Date

Signature & Official Stamp of Doctor

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