

 **Great Eastern**  
Life is Great  
A member of the OCBC Group

\* Please delete where appropriate

G	E	L	S	-							
O	A	C	S	-							

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 any disease or disorder of the heart valve:

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 heart disease that require heart valve surgery.

(d) Date when heart valve disease requiring surgery 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			

(g) Date when Life Assured first became aware that Heart Valve Surgery was necessary:

Day		Month		Year			

Signature of Doctor



3. (a) What type of surgery was performed?

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(b) Date of Surgery:

Day	Month	Year

(c) Was it an open-heart surgery?

YES / NO\*

If "NO", please state exact form of intervention.

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(d) Name and address of Hospital.

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(e) Name and address of Doctor who performed the surgery.

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4. (a) Has the Life Assured previously suffered from any related illness, e.g Hypertension, Angina, other Vascular Disease, Rheumatic Fever, etc? YES / NO\*

If "YES", please give dates of diagnosis, the resulting diagnosis, name and address of doctor and source of information.

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(b) Is there anything in the Life Assured's family history which would have increased the risk of heart valve disease? YES / NO\*

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

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(c) 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.

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Date

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Signature of Doctor

- (d) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO\*  
If "YES", please state illness, date of first diagnosis, name and address of attending doctor.

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5. (a) Please describe the Life Assured's mental and cognitive abilities.

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

6. (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

- (b) Please provide the names and addresses of any hospital or clinic to which the Life Assured was referred to and the names of the consultants referred.

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7. Please state and attach copies of results of cardiac catheterisation/echocardiogram report and other hospital, laboratory and test results.

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

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\_\_\_\_\_  
Date

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Signature & Official Stamp of Doctor