## LIVING ASSURANCE / EPCC CLAIM **DOCTOR'S STATEMENT**



DOCTOR'S STATEMENT FOR: LOSS OF SPEECH	For Official Use
* Please delete where appropriate	
	O A C S -
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?  If "YES", since what date?	YES/NO*
(a) Date when Life Assured first consulted you for the illness / disease / cond	lition causing Loss of Speech:
(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?  If "Others", please specify:  (c) Please provide full and exact details of the injury / disease / condition cau	Patient / Referring Doctor / Others * using Loss of Speech.
(d) Date when diagnosis of "Loss of Speech" was first made :  (e) Diagnosis was first made by (name of doctor) :	nth Year
(f) Date when Life Assured first became aware of such disease / condition :	Day Month Year
3. (a) Is the loss of speech due solely to the disease/injury to the vocal cord?  If "YES", please give details:	YES/NO:
(i) disease of vocal cord:	
(ii) injury to vocal cord:	
	Signature of Doctor



(b)	Were there any associated neurological or psychiatric conditions contributing to Life Assured's loss of speech? If "YES", please provide details.				
(c)	Is the Life Assured undergoing any speech therapy sessions and if so, please detail frequency a	and duration.			
(d)	Has there been any improvement in the Life Assured's speech since onset of the condition?				
(e)	What investigations or tests have been performed to verify the diagnosis of irrecoverable loss of	f speech?			
(f) (g)	Please confirm that the loss of speech is total and irreversible.  Has Life Assured been unable to speak for a continuous period of 12 months?		YES/NO <sup>2</sup>		
(a)	Has the Life Assured previously suffered from the condition specified above or any related illustrated illustrated in the condition of the con		YES/NC ource of		
(b)	Is there anything in the Life Assured's habits or personal medical history which would have incredif "YES", please give full details including the date of diagnosis and source of information.	eased the risk of loss	s of speech? YES/NO		
(c)	Is the Life Assured suffering or has suffered from any other significant illnesses?  If "YES", please state illness, date of first diagnosis and name and address of attending doctor.		YES/NO <sup>2</sup>		
		Signature of I	Doctor		

4.

5.	(a)	Please describe the Life Assured's mental and cognitive abiliites.					
	(b)	Is the Life Assured m	entally incapacitated in accord	ance to the Mental Capacity Ac	t (Chapter 177A of Singapore)?	YES / NO*	
6.	(a)			ness or its symptoms BEFORE e doctor(s) whom he /she cons		YES/NO <sup>3</sup>	
		Na	me of Doctor	Name of CI	inic / Hospital and Address		
	(b)	Please provide the n consultants attended.	ames and address of any hos	pital or clinic to which the Life	Assured was referred and the n	ames of the	
7.	Ple						
8.	Please provide us with any other additional information that will enable the Company to assess this claim.						
		 Date			Signature & Official Stamp of	of Doctor	