HOSPITALISATION CLAIM DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

* 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. (a) Has the Life Assured consulted any other doctors/ hospitals prior to first consultation with you? YES / NO*

If "YES", please provide name and address of the doctor(s)/ hospital(s).

(b) Are you the Life Assured's usual medical doctor? YES / NO*

If "YES", since when? Day Month Year

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

(b) Date(s) of subsequent consultation:

(c) Please state 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 known to the Life Assured: Day Month Year

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

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: MedicalClaims-SG@greateasternlife.com Website: greateasternlife.com

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

(i) If "YES", describe in detail how the accident happened. _____

_____

_____

(ii) Date of accident: Day | Month | Year

(iii) 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 quality consumed:

_____

(iv) Did the injuries result from a self-inflicted act? YES / NO*
If "YES", please give full description.

_____

_____

(j) Type of treatment/ medication given and the response.

_____

_____

(k) Please tick if the following were done/ will be done.

☐ Gamma Knife ☐ Radiotherapy ☐ Stereotactic Radiotherapy ☐ Erythropoietin

☐ Chemotherapy ☐ Kidney dialysis ☐ Cyclosporin ☐ Immunotherapy

(l) Is the current treatment related to the following conditions? YES / NO*
If "YES", please tick the box(es):

☐ Infertility ☐ Subfertility ☐ Abortion ☐ Birth control ☐ Sterilisation

☐ Impotence test or treatment

☐ Pregnancy, childbirth, miscarriage or their sequelae ☐ Complications of Pregnancy or childbirth

☐ Alcoholism ☐ Drug addiction ☐ Drug abuse

☐ Routine eye examination ☐ Refractive errors of the eyes

☐ Depression ☐ Mental disorder ☐ Functional disorder

☐ Hereditary conditions ☐ Birth defects ☐ Congenital sickness or abnormalities

☐ Obesity ☐ Weight reduction ☐ Weight improvement

☐ AIDS or any illness caused by or related to HIV ☐ Sexually-transmitted disease

_____ _____

Date Signature of Doctor

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If you have ticked any of the boxes, please give full details.

(m) Is the Life Assured still on follow-up treatment? YES / NO*
If "YES", please specify the type of treatment/ medication.

(n) How frequent does the Life Assured seek treatment since discharge from hospital?

(o) What is the expected length of follow up?

3. Please state the periods of hospitalisations.

Name of Hospital	Period(s) of Hospitalisation		Period(s) of Intensive Care	
	From	To	From	To

4. (a) Was surgery performed for this condition? YES / NO*
If "YES", please specify.

Nature of Surgical Operation(s)	Date(s) Performed (DD/MM/YY)	Surgical Table No.

(b) Is further surgery likely to be required? YES / NO*

If "YES",

(i) please specify the tentative date of surgery: Day Month Year

(ii) please specify the type of surgery to be performed:

Date

Signature of Doctor

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(c) Is the surgery performed an elective cosmetic or plastic surgery? YES / NO*
If "YES", please provide details.

_____

_____

5. (a) Has the Life Assured previously suffered from the same illness in respect of which he/ she is claiming now? YES / NO*
If "YES", please state:

(i) Date when illness was first diagnosed:

Day		Month		Year			

(ii) Name and address of the doctor who first treated him/ her.

_____

_____

(iii) Has the Life Assured fully recovered from the previous illness before the current episode? YES / NO*

(b) Has the Life Assured been admitted to any hospital before, either for the same or different cause? YES / NO*
If "YES", please state.

Period(s) of Hospitalisation	Diagnosis	Hospital	Name(s) of Attending Doctor(s)

(c) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*
If "YES", please state.

Brief Description of Illness(es)	Date(s) of First Diagnosis (DD/MM/YY)	Name & Address of Attending Doctor

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

_____

_____

_____

_____ _____

Date Signature & Official Stamp of Doctor

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