ACCIDENT CLAIM DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

For Official Use

G E L S –

O A C S –

Name of Life Assured:

NRIC/ Passport No.:

1. Date of Accident: Day Month Year

Date of first consultation for this current condition: Day Month Year

Date(s) of subsequent consultation(s):

If the Life Assured had consulted another doctor before consulting you, please give name and address of that doctor.

2. (a) Detailed description of the injuries.

(b) Please state the diagnosis:

(c) Detailed description of the accident.

(d) Were the injuries the result of the accident described above? YES / NO*

(e) (i) Were there any underlying illnesses/ conditions that attributed to the accident? YES / NO*

If "YES", please provide full details of condition (including the type of condition, the date of onset, the extent of physical/ mental infirmity) and describe how it attributed to the accident.

(ii) What was the proximate cause of the injuries/ disabilities?

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@greateasternlife.com Website: greateasternlife.com

CCLM
CCLMDOCACC

May 2016

(f) Was the Life Assured under the influence of alcohol/ drugs at the time of the accident? YES / NO*

If "YES", please state blood alcohol content/ drug type and quantity consumed: ____________________

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

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3. (a) What is the Life Assured's occupation and nature of work?

____

____

(b) Please state the period of Total Disability

(i) Period of *Total Disability: From: Day | Month | Year To: Day | Month | Year

*Total Disability refers to disability which prevents the Life Assured from performing each and every duty of his occupation.

(ii) Were medical certificates issued for the above stated period? YES / NO*

If "NO", please provide reasons: ____________________

____

(iii) How and to what extent does the Life Assured's total disability prevent him/ her from performing all duties of his/ her occupation as stated above?

____

____

(iv) If the Life Assured is still totally disabled, how long is the total disability expected to last?

____

(c) Please state the period of Partial Disability

(i) Period of **Partial Disability: From: Day | Month | Year To: Day | Month | Year

**Partially Disability refers to disability which prevent the Life Assured from performing one or more duty of his occupation.

____________________ ____________________
Date Signature of Doctor

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(ii) Were medical certificates issued for the above stated period? YES / NO*

If "NO", please provide reasons: ____________________

____

(iii) What are some of the duties and to what extent of the Life Assured's occupation that he/ she is unable to perform as a result of his/ her partial disabilities?

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____

(iv) If the Life Assured is still partially disabled, how long is the partial disability expected to last?

____

(d) If Life Assured had been hospitalised or had undergone surgery, please state:

(i) Date admitted: Day | Month | Year

(ii) Date discharged: Day | Month | Year

(iii) Name of Hospital: ____________________

(iv) Nature of Surgical Procedure: ____________________

____

(v) Date of Surgical Procedure: Day | Month | Year

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

If "YES", please specify tentative date of surgery: Day | Month | Year

4. (a) Was the Life Assured suffering from any illness/ infirmity which was likely to protract the period of disability? YES / NO*

If "YES", please give details:

(i) Date of first diagnosis: Day | Month | Year

(ii) Diagnosis: ____________________

(iii) Name and address of doctor who made diagnosis:

____

(iv) How it protracts the period of disability:

____

____

(b) What would be the usual recovery time if the Life Assured did not have the illness/ infirmity?

____

____

____________________ Date

____________________ Signature & Official Stamp of Doctor

5. 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)

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

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____

______________________ Date

______________________ Signature & Official Stamp of Doctor

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