GOLDEN PROTECTOR 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 the 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 caused solely by 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?

(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:

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
CCLMDOCGPP

May 2016

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

_____

_____

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

_____

_____

4. 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

5. Did the Life Assured suffer any fractures, dislocations or burns? YES / NO*

If "YES", please tick where applicable.

(i) Fractures of hip or pelvis (excluding thigh or coccyx)

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Mulitple fractures, at least one complete ☐ Others fractures

(ii) Fractures of thigh or heel

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Multiple fractures, at least one complete ☐ Other fractures

(iii) Fractures of lower leg, skull, claride, ankle, elbows, upper or lower arm (including wrists but excluding collen-type fractures)

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Depressed fracture of the skull needing surgical intervention ☐ Other fractures

☐ Multiple fractures, at least one complete

_____ _____

Date Signature of Doctor

Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

(iv) Fractures of collen-type fracture of the lower arm

☐ Compound fracture ☐ Other fractures

(v) Fractures of shoulder blade, knee cap, sternum, hand (excluding fingers and wrists), foot (excluding toes or heel)

☐ All compound fractures ☐ Other fractures

(vi) Fractures of spinal column (vertebrae but excluding coccyx)

☐ All compressions fractures ☐ All spinous, transvere process of pedicle fractures

☐ Fracture leading to permanent neurological damage ☐ Other vertebrae fractures

(vii) Fractures of lower jaw

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Multiple fractures, at least one complete ☐ Other fractures

(viii) Fractures of rib or ribs, cheek bone, coccyx, upper jaw, nose, toe or toes, finger or fingers

☐ Multiple fractures, at least one compound and at least one complete ☐ All other compound fractures

☐ Multiple fractures, at least one complete ☐ O ther fractures

(ix) Burns: 2nd or 3rd degree burns on

☐ at least 27% of body surface ☐ at least 18% of body surface

☐ at least 9% of body surface ☐ at least 4.5% of body surface

(x) Dislocations requiring surgery under anaesthesia

☐ Spine or back, diagnosed by X-ray (excluding slipped disc) ☐ Hip

☐ Knee ☐ Wrist or elbow

☐ Ankle, shoulder blade or collarbone ☐ Fingers, toes or jaw

☐ Internal injuries resulting in open abdominal or thoracic surgery (excluding hernia)

Date

Signature of Doctor

Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

6. ACTIVITIES OF DAILY LIVING ("ADL") FUNCTION

(a) Please tick as applicable in relation to the Life Assured's ADL ability.

Notes:
"NO assistance" means the Life Assured requires no assistance to perform the ADL.
"SOME assistance" means the Life Assured requires some assistance of another person up to 74% of the time to perform the ADL.
"SUBSTANTIAL assistance" means the Life Assured requires another person at least 75% of the time to perform the ADL.
"FULL assistance" means the Life Assured is not able to perform the ADL even with the aid of the special equipment, and always requiring the physical help of another person throughout the entire ADL.

(i) Washing
(ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(ii) Dressing
(ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(iii) Toileting
(ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(iv) Mobility
(ability to move indoors from room to room on level surfaces.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

_____ _____

Date Signature of Doctor

(v) Transferring
(ability to move from a bed to an upright chair or wheelchair and vice versa.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

(iv) Feeding
(ability to feed oneself food after it has been prepared and made available.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

7. (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 of the injuries if the Life Assured did not have the illness/ infirmity?

8. 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)

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

Date

Signature & Official Stamp of Doctor

Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com