CANCERCARE CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

* Please delete where appropriate

For Official Use
G E L S –

Name of Life Assured:

NRIC/ Passport No.: Date of Birth (dd/mm/yyyy): Gender: M / F *

1. 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

2 TREATMENT

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

If "YES", since what date? Day Month Year

(b) Date of first consultation for the current condition: Day Month Year

(c) Date(s) of subsequent consultation(s): _____

(d) Please state symptoms presented and dates symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YY)

What is the source of the above information? Life Assured/ Referring Doctor/ Others*

If "Others", please specify the name of the person and relationship to the Life Assured:

_____

Date

Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Claims Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

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Jun 2017

(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?

_____

3 DIAGNOSIS OF CANCER

(a) What was the site or organ involved and the precise histology of the tumour?

_____

_____

(b) What stage did the disease reach? Please describe this using whatever staging classification (e.g. TMN classification, etc) that is appropriate.

_____

_____

(i) Was the disease completely localised? YES / NO*

(ii) Was there invasion of adjacent tissues? YES / NO*

(iii) Were regional lymph nodes involved? YES / NO*

(iv) Were there distant metastases? YES / NO*

(c) If the diagnosis is leukaemia, please provide details of the actual type.

_____

_____

(d) If the diagnosis is malignant melanoma, please provide details of size, thickness (Breslow classification) and depth of invasion.

_____

_____

(e) In your opinion, please state if the advent of death is highly likely within 12 months (for Hospice Care benefit).

_____

_____

_____ _____

Date Signature of Doctor

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(f) Is the Life assured employed in the following industries? YES / NO*

- ☐ Industries in contact with radioactive materials, asbestos, abrasive products
- ☐ Industries in contact with long term exposure to organic solvents such as painter, chemical engineers
- ☐ Industries in contact with long term exposure to pesticides
- ☐ Dry cleaning, laundry and ironing workers
- ☐ Manufacturing of tobacco products

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

_____

_____

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

_____

_____

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

- ☐ Radiotherapy
- ☐ Immunotherapy
- ☐ Stereotactic Radiotherapy
- ☐ Chemotherapy
- ☐ Hormone Therapy

(i) Is the current treatment related to the following conditions? YES / NO*

If "YES", please tick the boxes.

- ☐ Pregnancy, childbirth, miscarriage or their sequelae, abortion, birth control, sterilisation, infertility or impotence tests or treatment.
- ☐ Alcoholism.
- ☐ Drug Addiction.
- ☐ Psychiatric treatment or treatment of mental or function disorder.
- ☐ Sexually-transmitted disease, AIDS or any illness caused by or related to the Human Immunodeficiency Virus.
- ☐ Self-inflicted injuries or attempted suicide, whether sane or insane.
- ☐ Resulting from nuclear weapon materials, ionizing radiation or contamination by radioactivity from any nuclear waste or from the combustion of nuclear fuel.

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

_____

_____

_____ _____

Date Signature of Doctor

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(j) Is the Life Assured still on follow-up treatment? YES / NO*

If "YES", please specify the type of treatment/ medication.

(k) How frequently does the Life Assured seek treatment since discharge from hospital?

(l) What is the expected length of follow-up?

(m) Is there any purchase or rental of durable medical equipment? YES / NO*

If "YES", please state the durable medical equipment purchased or rented.

4 HOSPITALISATION

Please state the periods of hospitalisations.

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

5 SURGERY (if applicable)

(a) Was surgery performed for this condition? YES / NO*

(i) If "YES", please specify.

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

Date

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(ii) Was any surgical prosthesis used? YES / NO*

If "YES", please state the surgical prosthesis used.

_____

_____

(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:

_____

(c) Is the surgery performed an elective comestic or plastic surgery? YES / NO*

If "YES", please provide details.

_____

_____

_____

6 MEDICAL HISTORY

(a) Has the Life Assured previously suffered from the same illness in respect of which he 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)

_____ _____

Date Signature of Doctor

(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

7. 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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