LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
MULTIPLE SCLEROSIS

* 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. Are you the Life Assured's usual medical doctor? YES/NO*

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

2. (a) Date when Life Assured first consulted you for Multiple Sclerosis: Day Month Year

(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 information? Patient / Referring Doctor / Others*

If "Others", please specify: _____

(c) Please provide full and exact diagnosis of Life Assured's condition.

_____

_____

(d) Date when illness/condition was FIRST diagnosed: Day Month Year

(e) Diagnosis was first made by (name of doctor) : _____

(f) Date when Life Assured first became aware of the illness : Day Month Year

_____ _____

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

3. (a) Please provide details, including dates, of the extent of his/her neurological deficit.

_____

_____

(b) Were there multiple neurological deficits occuring over a continuous period of at least 6 months? YES / NO*
If “YES”, please give details (including dates of each episode):

_____

_____

(c) Is there a well-documented history of exacerbations and remissions of said symptoms or neurological deficits? YES / NO*

(d) Please provide details of all investigations performed. Please comment on whether the diagnosis was supported by MRI/CTscan.

_____

_____

(e) Please give details of current treatment.

_____

_____

4. Has the Life Assured previously suffered from the condition specified above or any possible related illness, especially any consultations, however minor in nature, concerning neurological symptoms or complaints ? YES/NO*

If "YES", please give dates of diagnosis, their resulting diagnosis, the name and address of the doctor who made these diagnosis and source of information.

_____

_____

5. (a) Please describe the Life Assured’s mental and cognitive abilities.

_____

_____

(b) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

_____ Date

_____ Signature of Doctor

6. (a) 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

(b) Please provide the names and addresses of any hospital or clinic to which the Life Assured was referred to and the names of the consultants attended.

7. Please state and attach copies of all hospital, MRI/CT scan, laboratory and test results.

8. 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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