LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
CHRONIC LUNG DISEASE / END STAGE LUNG DISEASE / SEVERE ASTHMA

* 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 End Stage Lung Failure/Severe Asthma/Lung Condition: Day Month Year
(Please circle the appropriate condition)

(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 this information? Patient / Referring Doctor / Others*

If "Others", please specify: _____

(c) Please provide full and exact diagnosis of the 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/condition: 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) Has the Life Assured's lung disease reach end-stage? YES / NO*

If "YES", please provide the date when End Stage Lung Disease was FIRST diagnosed:

Day		Month		Year			

(b) Please provide details of all investigations carried out, particularly pulmonary function tests including dates and results. (Please include current FEV 1 and vital capacity readings.)

(c) Does the Life Assured require extensive and permanent oxygen therapy for hypoxemia? YES / NO*

If "YES", please provide the start date:

Day		Month		Year			

(d) Is there dyspnea at rest? YES / NO*

(e) Is Life Assured's PaO2 < 55 mmHG? YES / NO*

If "YES", please provide full details of all arterial blood gas analysis results.

This section is applicable to severe asthma condition only.

4. (a) Is there evidence of acute attack of severe asthma with persistent status asthmaticus? YES / NO*

If "YES", please provide details.

(b) Was the Life Assured hospitalised and required assisted ventilation with a mechanical ventilator for a continuous period of at least 4 hours? YES / NO*

If "YES", please explain.

Date

Signature of Doctor

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This section is applicable to pulmonary emboli condition only.

5. (a) Date when Life Assured first consulted you for pulmonary emboli: Day | Month | Year

(b) Date of any subsequent pulmonary embolism. Please provide dates of every recurrence.

Date	Medical Condition	Treatment Provided	Patient's Response	Name and Address of the doctor

(c) Is there surgical insertion of vena-cava filter? YES / NO*
If "YES", please state the following:

(i) Date of surgery: Day | Month | Year

(ii) Was the surgery absolutely necessary? YES / NO*

(iii) Is there other alternate treatment which could also treat the Life Assured's condition? YES / NO*
If "YES", please state the type of treatment.

_____

_____

This section is applicable to pneumonectomy or complete surgical removal of a lung condition only.

6. (a) Date of surgery: Day | Month | Year

(b) Reason(s) for requiring this surgery.

_____

_____

(c) Was the surgery absolutely necessary? Please attach a copy of surgery and histology report. YES / NO*

_____ Date

_____ Signature of Doctor

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7. (a) Has the Life Assured previously suffered from any illness related to the lung disease? YES / NO*
If "YES", please give dates of consultations, the diagnosis, the name and address of the doctor who made the diagnosis and source of information.

(b) Is there anything in the Life Assured's family history which would have increased the risk of lung disease? YES / NO*
If "YES", please give full details including the relationship, nature of illness, date of diagnosis and source of information.

(c) Please give details of the Life Assured's habits in relation to cigarette smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of information.

(d) Is the Life Assured suffering or has suffered from any other significant illnesses? YES / NO*
If "YES", please state illness, date of first diagnosis and name and address of attending doctor.

8. (a) Please describe the Life Assured's mental and cognitive abiliites.

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

Date

Signature of Doctor

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9. (a) Did the Life Assured consult any other doctor for 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, together with the names of the consultants attended.

_____

_____

10. Please state and attach copies of all relevant hospital reports, laboratory and test results.

_____

_____

11. 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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