LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
ENCEPHALITIS

* 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 Encephalitis: 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 this information? Patient / Referring Doctor / Others*

   If "Others", please specify: _____

   (c) Diagnosis: _____

   _____

   (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

3. (a) What was the cause of the disease?

   _____

   _____

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

Jun 2017

CCLM
CCLMDOCLAP

(b) Was there any neurological deficit 6 weeks after the date of diagnosis of Life Assured's Encephalitis? YES / NO*

If "YES", please give full details.

(c) Is this neurological deficit likely to be permanent? YES / NO*

(d) Is the disease caused by HIV infection? YES / NO*

If "YES", please provide details.

(e) What is the prognosis?

4. (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*

5. (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.

Date

Signature of Doctor

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6. Please state and attach copies of all relevant hospital reports, laboratory and tests results.

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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