LIVING ASSURANCE / EPCC CLAIM
DOCTOR'S STATEMENT

Great Eastern
A member of the OCBC Group

DOCTOR'S STATEMENT FOR:
KIDNEY FAILURE

For Official Use
G E L S –

Please attach copies of the following (if applicable):

1. eGFR results
2. All relevant hospital / operation reports, laboratory and test results

* Please delete where appropriate

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 Kidney Disease: Day Month Year

(b) What is the underlying cause of kidney disease?

(c) Please state symptoms presented and date symptoms first appeared.

Symptoms	Duration of Symptoms	Date Symptoms First Started (DD/MM/YYYY)

(d) What is the source of the above information? Patient / Referring Doctor / Others*

If "Referring Doctor / Others", please specify name & address:

Name	Address

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

(e) Please provide exact diagnosis (e.g. type of kidney disease).

(f) Was the illness suffered by Life Assured caused directly or indirectly by alcohol or drug abuse? YES / NO*
If "YES", please give details.

3. (a) Please state if the kidney disease has resulted in permanent impaired renal function? YES / NO*
If "YES", what is the eGFR level?

(b) Was the eGFR < 15 ml/min/1.73m^2 body surface area? YES / NO*

If "YES", has the above result persisted for a period of at least 6 months? YES / NO*

If "NO", how long has it persisted?

(c) Please provide us the results of all the eGFR tests done.

Date	eGFR level

4. (a) Did the kidney disease result in kidney failure? YES / NO*

(b) If "YES", please state whether one or both kidneys have failed?

Date

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5. (a) Does the Life Assured currently require peritoneal dialysis or haemodialysis? YES / NO*

(b) If "YES", please state date of FIRST dialysis:

Day		Month		Year			

(c) Please state the number of dialysis per week: _____

6. (a) Was there any surgical removal of one or both kidneys? YES / NO*

If "YES", please confirm the following:-

(i) Number of kidney which is surgically removed. _____

(ii) State Right or Left kidney. _____

(iii) Date of surgical removal of kidney(s):

Day		Month		Year			

7. (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*

8. Does the Life Assured have any other medical conditions? YES / NO*

If "YES", please state medical condition, date of diagnosis, name and address of treating doctor.

Medical Conditions	Diagnosis Date (DD/MM/YYYY)	Name and Address of Doctor who treated Life Assured

9. Does the Life Assured have any family history? YES / NO*

If "YES", please provide details including relationship to the Life Assured, nature of condition and age of onset.

Relationship to the Life Assured	Nature of Condition	Age of Onset

_____ _____

Date Signature of Doctor

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

11. Please give details of the Life Assured's habit in relation to alcohol consumption including the amount of alcohol consumption per day and source of information.

12. Please provide any other information which may be of assistance to us in assessing this claim.

Date

Signature & Official Stamp of Doctor

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